Module 2:
Your Medicare Rights and Protections

National Medicare
TRAINING PROGRAM

...helping people with Medicare make informed health care decisions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet
Module 2
Medicare Rights & Protections

Module Description

Module 2-Your Medicare Rights and Protections explains the rights and protections afforded to people enrolled in Original Medicare, Medicare health plans (such as a Medicare Advantage Plans), Medicare Prescription Drug Plans, and other Medicare health plans (such as a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly). This module also describes appeals processes and timeframes.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics
2	Session Objectives
4-12	Overview of Your Rights & Protections
13-27	Your Rights in Original Medicare
28-34	Your Rights in MA Plans & Other Plans
35-52	Rights in Medicare Prescription Drug Plans
53-56	Your Rights in Other Settings
57-64	Medicare Privacy Practices
65-70	Information Sources

Objectives

- Explain Medicare rights and protections
- Understand Medicare privacy practices
- Find more information and resources

Target Audience

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Learning Activities

This module contains six interactive learning questions, scenarios and case studies designed to prompt discussion and give participants the opportunity to apply the module concepts in a real-world setting.

Handouts

Slides 19, 29, and 43 are provided as full page handouts in the Appendix of this workbook. You may want to refer to these during your training if you provide copies of the workbooks to attendees. You may also wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 66 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

References

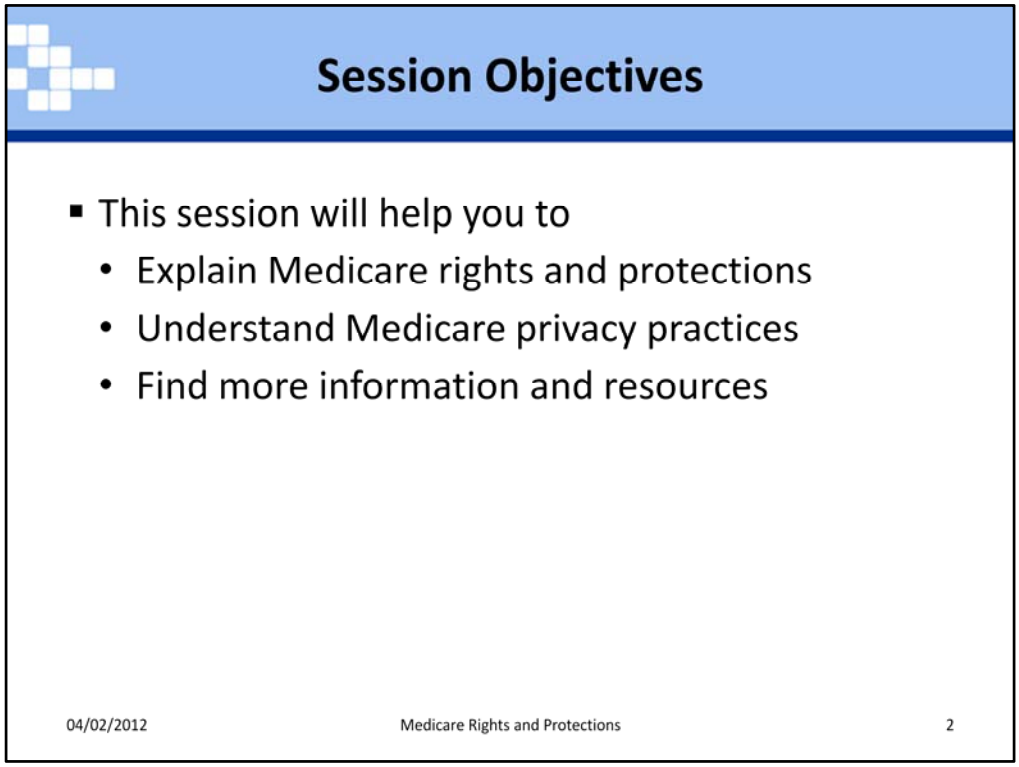
- *Your Medicare Rights and Protections, CMS Product No. 10112, available at medicare.gov/ Publications/Pubs/pdf/10112.pdf.*

Module 2 *Medicare Rights and Protections* explains the rights and protections afforded to you whether you are enrolled in Original Medicare, a Medicare Advantage Plan (like an HMO or PPO), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or Medicare Prescription Drug Plan.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare , Medicaid, Children's Health Insurance Program and Pre-Existing Condition Insurance Plans.

The information in this module was correct as of April 2012. To check for an updated version of this training module, visit cms.gov/NationalMedicareTrainingProgram/TL/list.asp on the Web. To check for updates regarding Affordable Care Act, visit www.healthcare.gov.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.



This session will help you

- Explain Medicare rights and protections
- Understand Medicare privacy practices
- Find more information and resources

This module includes lessons on

1. Rights for All People with Medicare
2. Rights in Original Medicare
3. Rights in Medicare Advantage Plans and Other Medicare Plans
4. Rights in Medicare Prescription Drug Plans
5. Rights in Other Settings
6. Medicare Privacy Practices
7. Information Sources for Medicare Rights and Protections

Lesson 1 explains the guaranteed rights and protections that are available to everyone with Medicare.

No matter how you get your Medicare, you have certain rights and protections designed to

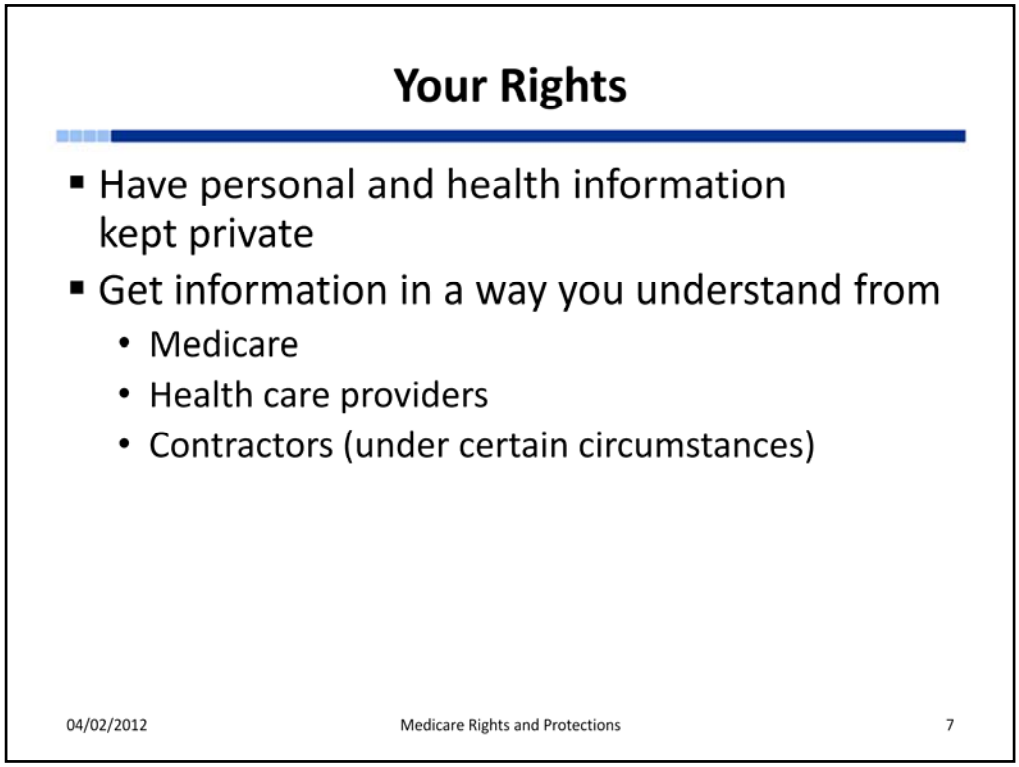
- Protect you when you get health care
- Make sure you get the medically necessary health care services that the law says you can get
- Protect you against unethical practices
- Protect your privacy

All people with Medicare have the right to

- Be treated with dignity and respect at all times
- Be protected from discrimination
  - Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of
    - Race
    - Color
    - National origin
    - Disability
    - Age
    - Religion
    - Sex

These protections are generally limited to complaints of discrimination filed against providers of health and social services who receive Federal financial assistance.

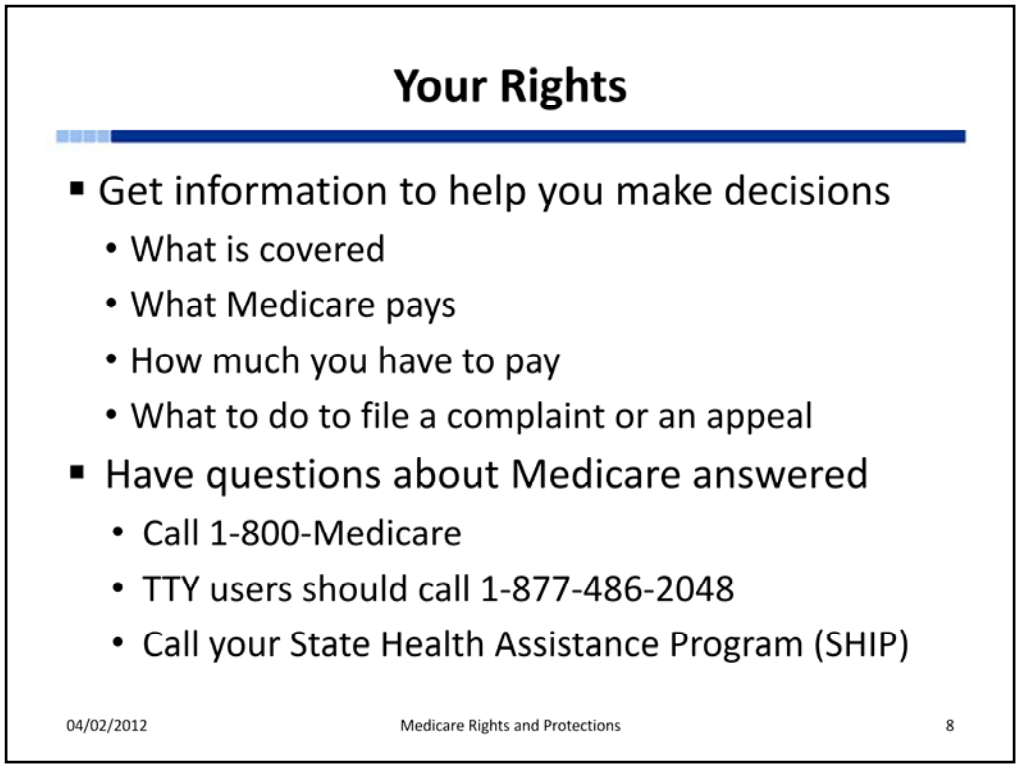
If you think you haven't been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or visit hhs.gov/ocr. TTY users should call 1-800-537-7697.



All people with Medicare have the right to

- Have your personal and health information kept private.
  - To learn more about this right
    - If you have Original Medicare, see the "Notice of Privacy Practices for Original Medicare" in your "Medicare & You" handbook. Visit www.medicare.gov/Publications to view the handbook or call 1-800-MEDICARE to ask for a copy.
    - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

Get information in a way you understand from Medicare, health care providers, and under certain circumstances, contractors.



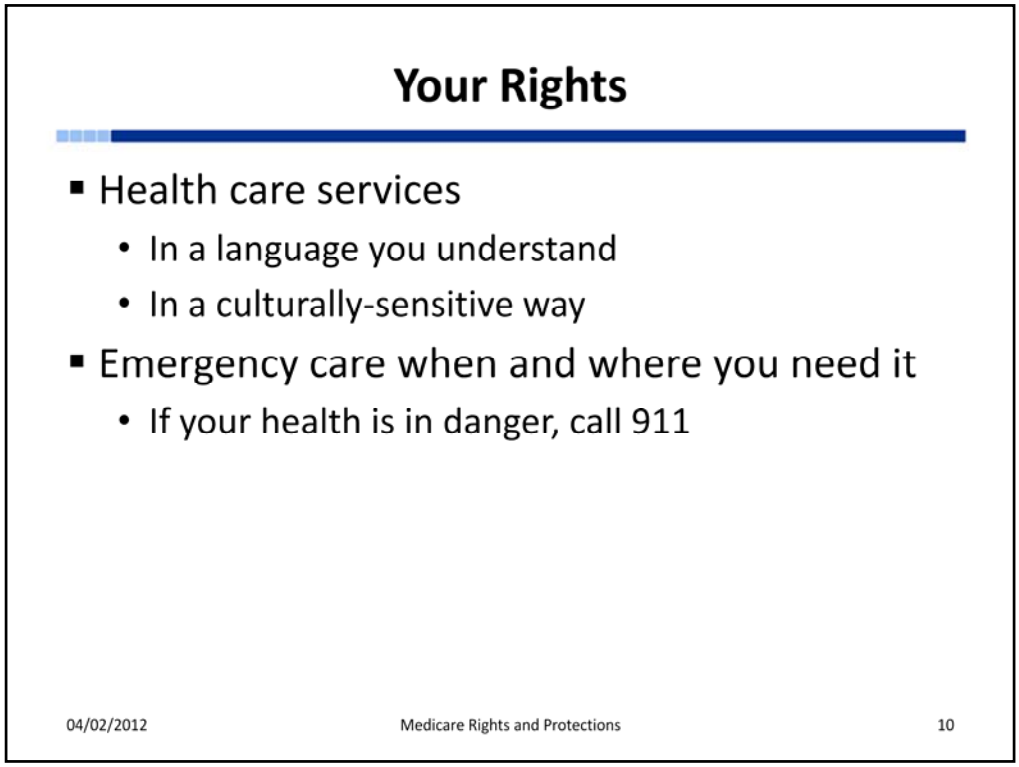
All people with Medicare have the right to

- Get understandable information about Medicare to help you make health care decisions, including what is covered, what Medicare pays, how much you have to pay, and what to do if you want to file a complaint or an appeal
- Have your questions about Medicare answered:
  - Visit www.medicare.gov.
  - Call 1-800-MEDICARE. TTY users should call 1-877-486-2048.
  - Call your State Health Insurance Assistance Program (SHIP). To get the most up-to-date SHIP phone numbers, call 1-800-MEDICARE, or visit www.medicare.gov/contacts.

Call your plan if you're in a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan.

All people with Medicare have the right to

- Have access to doctors, specialists, and hospitals.
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions.
- Participate fully in all your health care decisions. If you can't fully participate, ask a family member, friend, or anyone you trust to help you make a decision about what treatment is right for you.



All people with Medicare have the right to

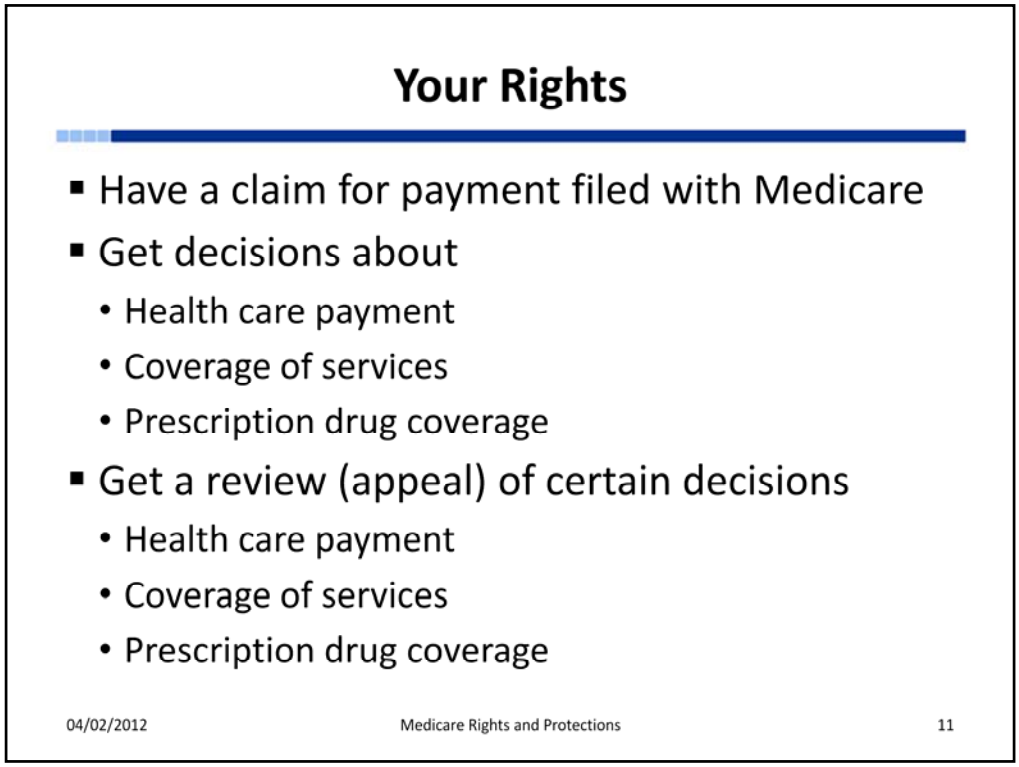
- Get health care services in a language you understand and in a culturally-sensitive way.
- For more information about getting health care services in languages other than English, call the Office for Civil Rights at 1-800-368-1019, or visit www.hhs.gov/ocr. TTY users should call 1-800-537-7697.

Get emergency care when and where you need it

- If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.

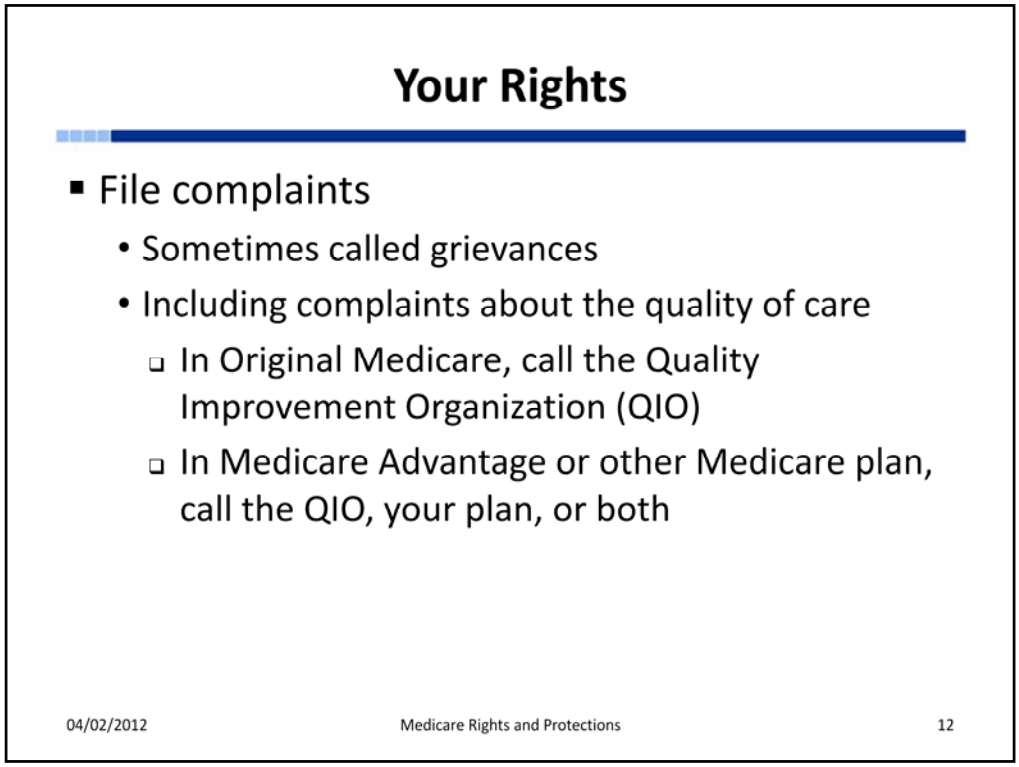
To learn about emergency care

- In Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- In a Medicare Advantage Plan or other Medicare health plan, your plan materials describe how to get emergency care



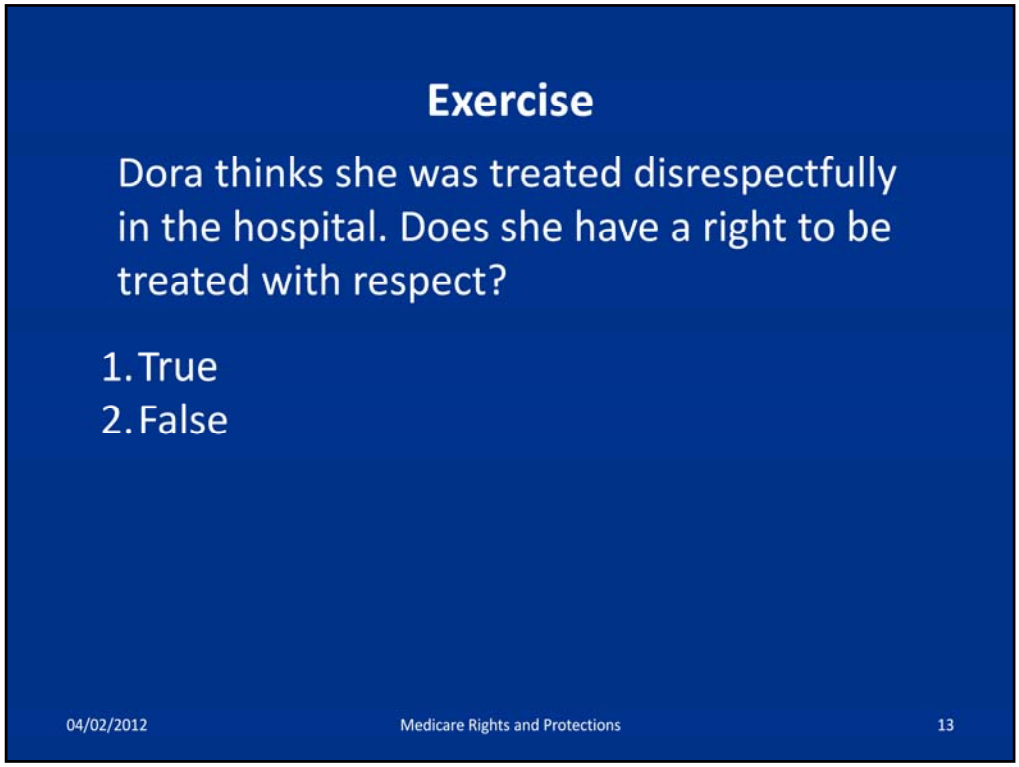
All people with Medicare have the right to

- Have a claim for payment filed with Medicare and get a decision about health care payment, services, or prescription drug coverage even when your doctor says that Medicare won't pay for a certain item or service.
  - When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.
- Get a review of certain decisions about health care payment, coverage of services, and prescription drug coverage. This type of review is known as an appeal.
- If you disagree with a decision about your claims or services, you have the right to appeal. For more information visit www.medicare.gov/appeals.
- Call the SHIP in your state. To get the most up-to-date SHIP phone numbers, call 1-800-MEDICARE, or visit www.medicare.gov/contacts. TTY users should call 1-877-486-2048.
  - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.



In addition to the rights just mentioned, all people with Medicare have the right to

- File complaints or grievances about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
- If you're concerned about the quality of care you're getting
  - In Original Medicare, call the Quality Improvement Organization (QIO) in your state to file a complaint. Call 1-800-MEDICARE or visit www.medicare.gov/contacts to get your QIO's phone number.
  - In a Medicare Advantage or other Medicare health plan, call the QIO, your plan, or both. If you have End-Stage Renal Disease and have a complaint about your care, call the ESRD Network in your state. To get this phone number, call 1-800-MEDICARE, or visit www.medicare.gov/contacts.



Exercise

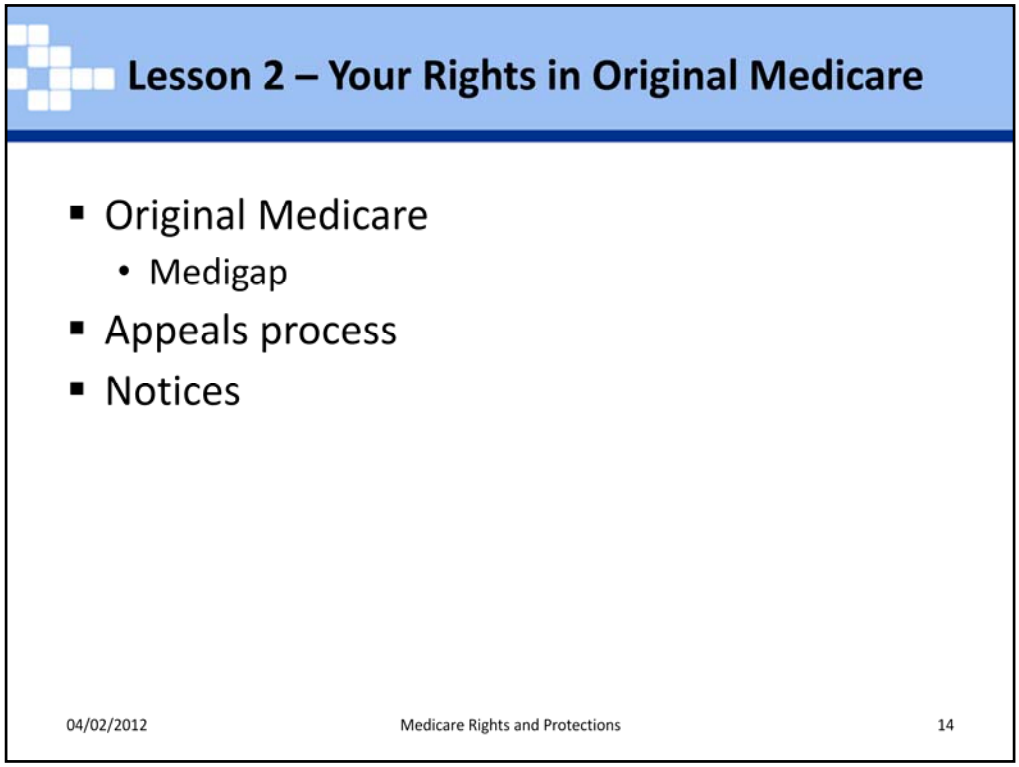
Dora thinks she was treated disrespectfully in the hospital. Does she have a right to be treated with respect?

1. True
2. False

Answer: 1. True. Dora has a right to be treated with dignity. Dora can file a quality of care complaint with the QIO.

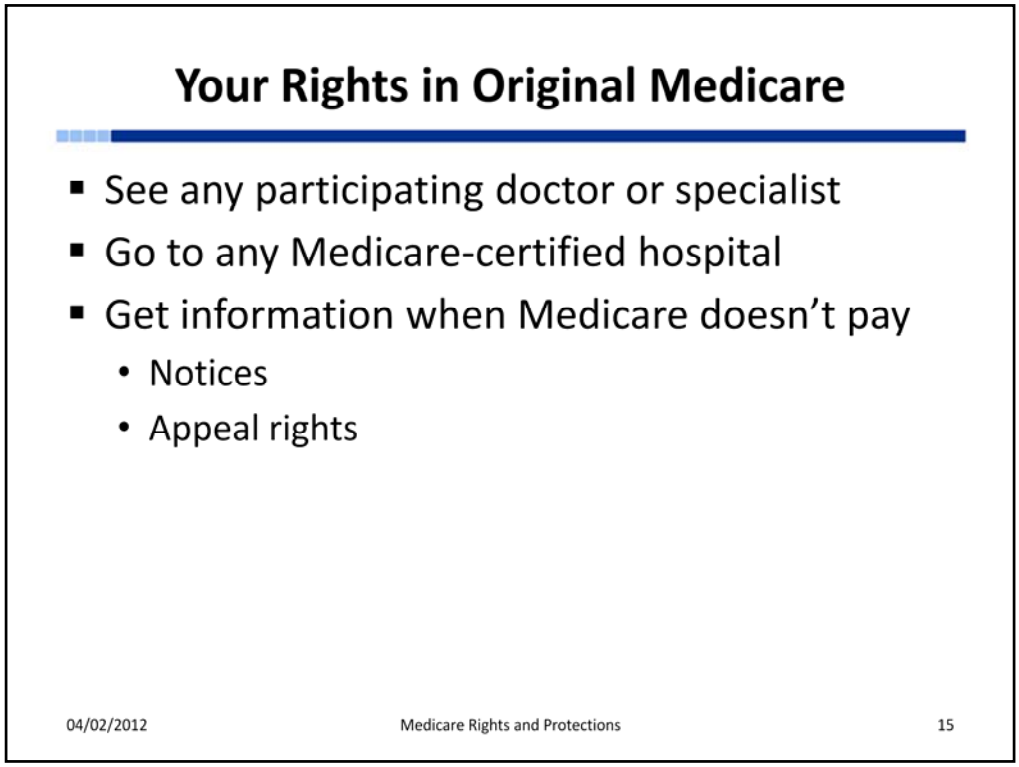
What other options might Dora have?

- She could also file a complaint with the Joint Commission by calling 1-630-792-5000 or she may submit her complaint online by visiting their website at jointcommission.org
- Another option would be to contact the DHHS/Office of Civil Rights by calling 1-866-627-7748 or 1-800-537-7697 for TTY users she may also visit the OCR website at hhs.gov/ocr/office/index.html



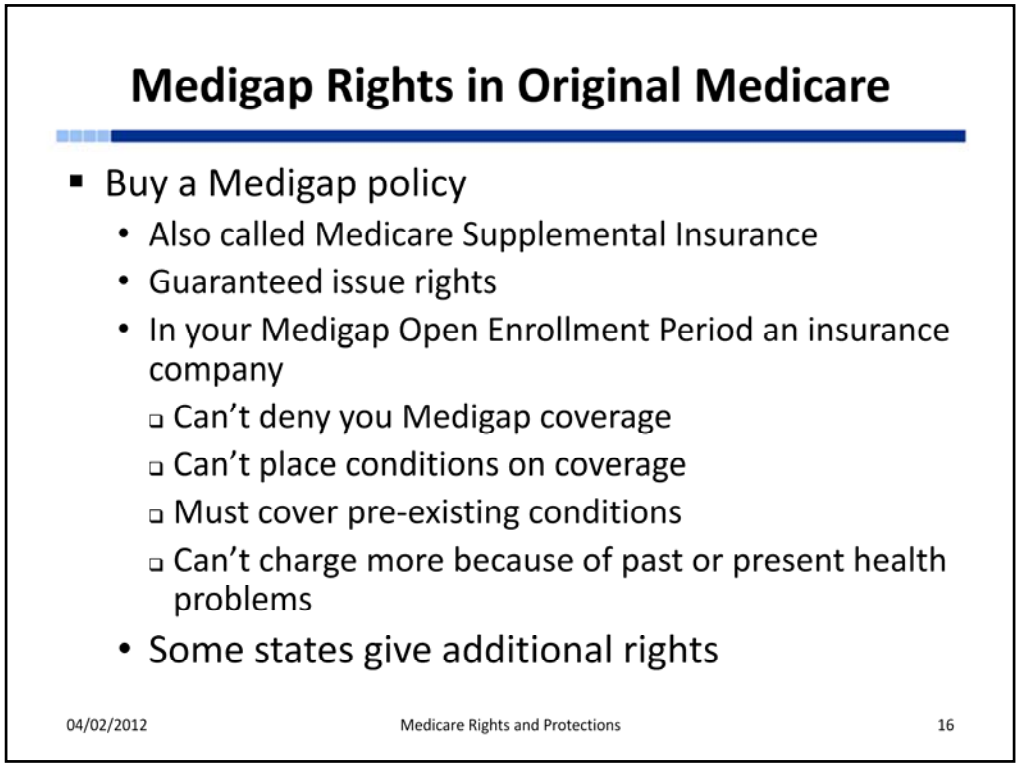
Lesson 2 explains the additional rights you have when enrolled in Original Medicare, including

- Original Medicare
- Medigap
- Appeals process
- Notices



Your rights when you are enrolled in Original Medicare include the following

- The right to see any participating doctor or specialist (including women's health specialists)
- Go to any Medicare-certified hospital
- Get certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care



Your rights when you are enrolled in Original Medicare include the following:

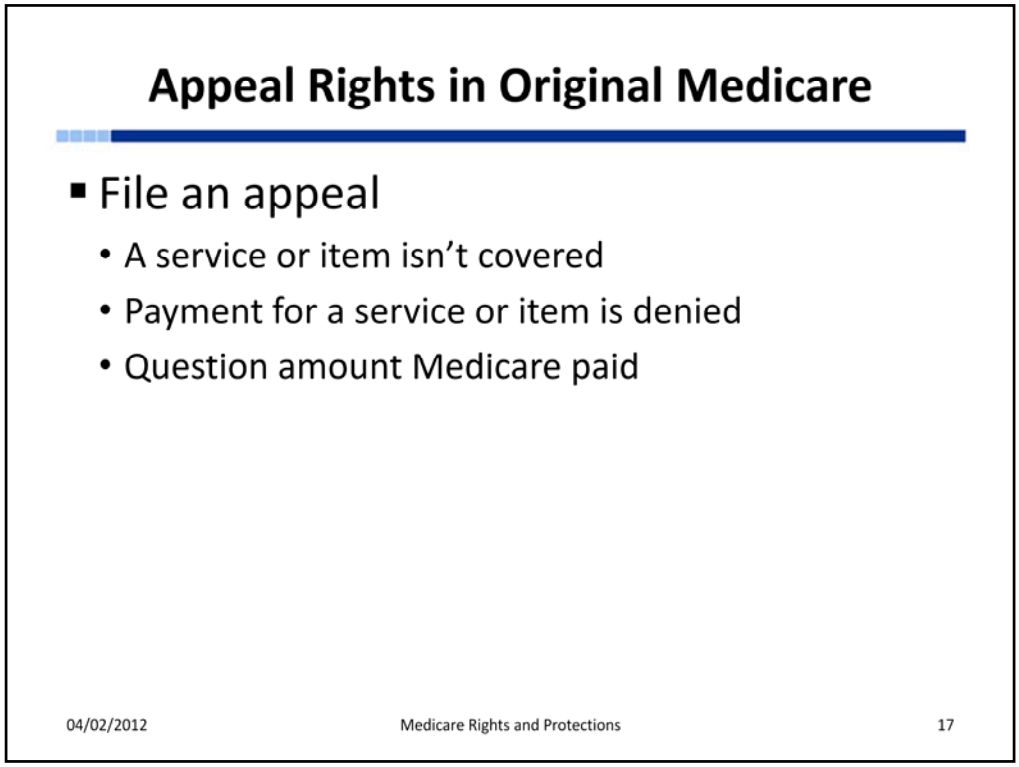
- Buy a Medigap (Medicare Supplemental Insurance) policy.
  - In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare coverage, such as coinsurance amounts.
  - Medigap policies must follow Federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
  - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a "standardized" Medigap policy. These policies are identified by the letters A,B,C,D,F,G,K,L,M, and N.
    - The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
  - You have the right to buy a Medigap policy during your Medigap open enrollment period. While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage of a pre-existing condition.

When you have guaranteed issue rights, the Medigap plan

- Can't deny you Medigap coverage or place conditions on your policy
- Must cover you for pre-existing conditions
- Can't charge you more for a policy because of past or present health problems

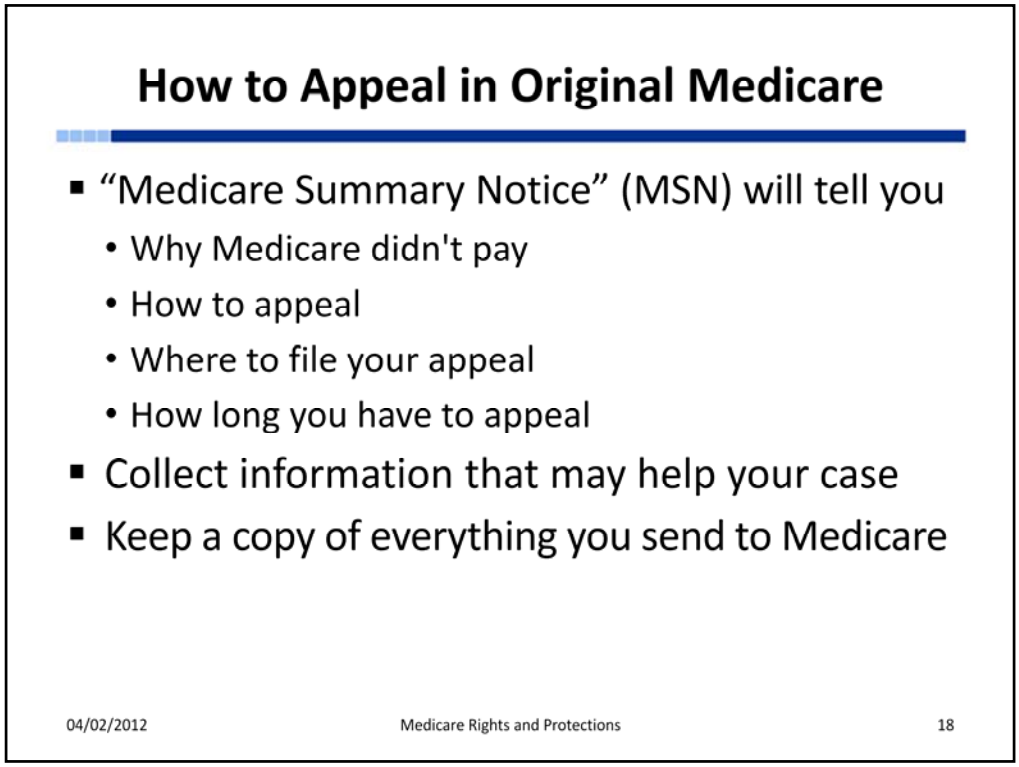
Some states offer additional rights to purchase Medigap policies.

NOTE: Module 3, *Medigap*, describes these situations.



In Original Medicare, you have the right to a fair, timely, and efficient appeals process. You can file an appeal if

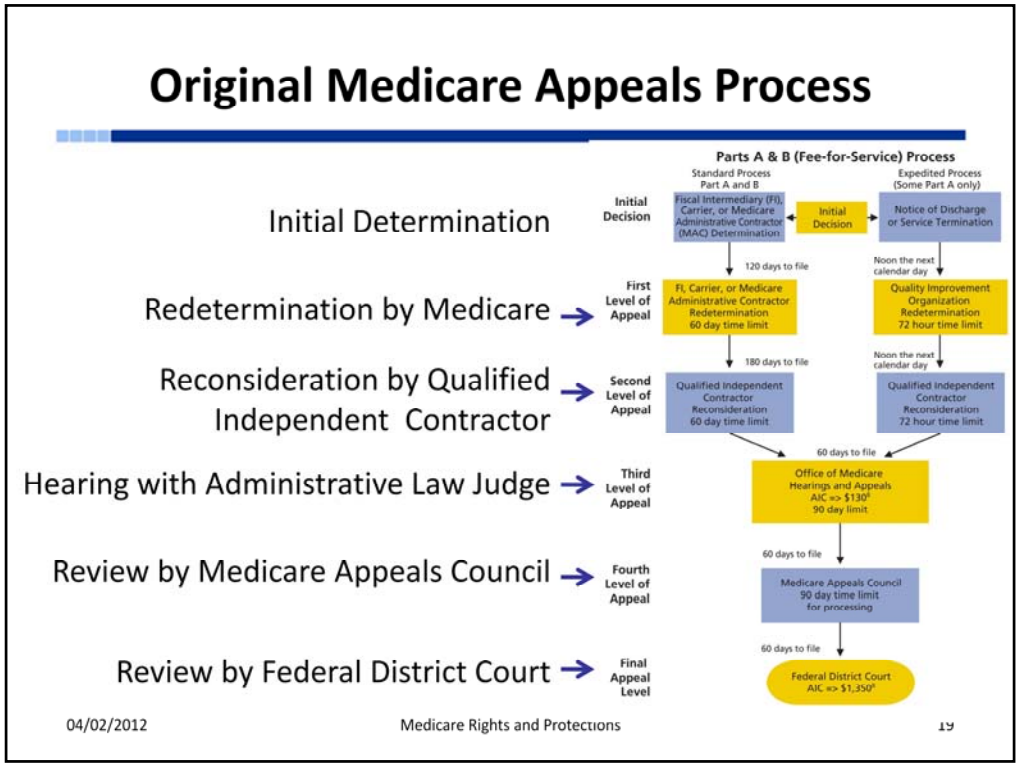
- A service or item you got isn't covered and you think it should be
- Payment for a service or item is denied and you think Medicare should pay for it
- You question the amount that Medicare paid for a service



In Original Medicare, when you get a Medicare-covered item or service, you will get a "Medicare Summary Notice" (MSN). This notice will tell you

- Why Medicare didn't pay
- How to appeal
- Where to file your appeal
- How long you have to appeal

If you decide to appeal, ask your doctor, health care provider, or DME (durable medical equipment) supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.



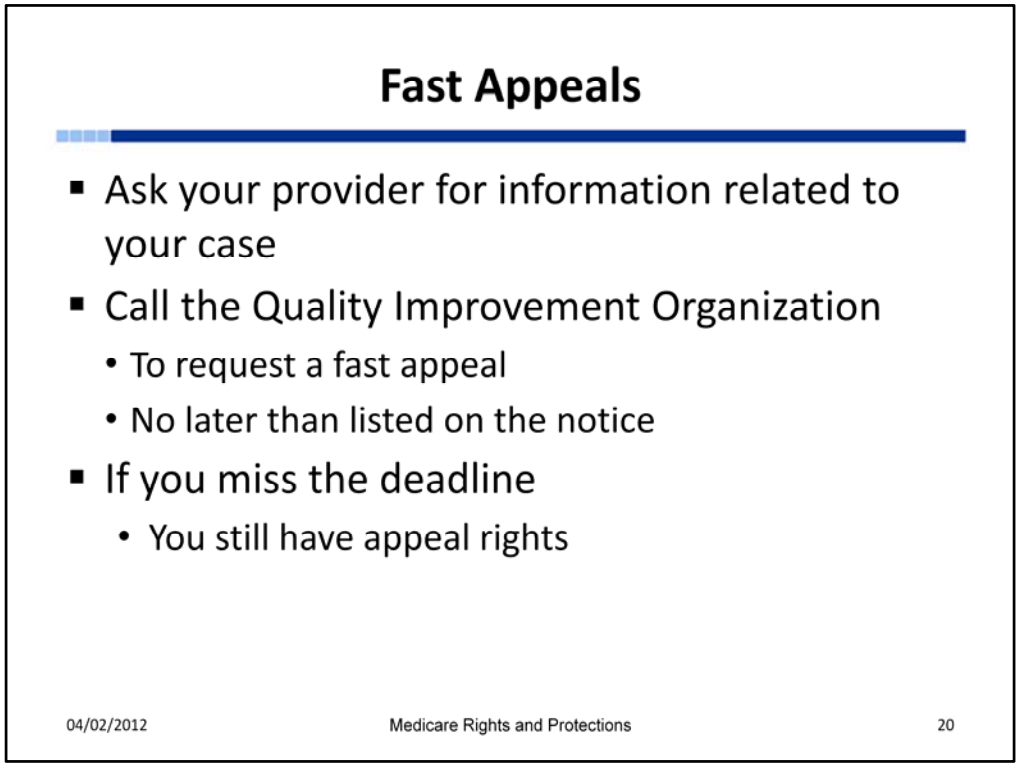
There are **five** levels in the appeals process in Original Medicare. Look at the job aid section of your resource card or the National Medicare Training Program website for a chart of the Part A, B, C, and D Appeals Processes.

There is a standard process and an expedited process. It is important to note that for an expedited appeal, a provider must decide to terminate services or discharge you.

1. **Redetermination by the company that handles claims for Medicare within 120 days** from the date you get the MSN. Details are on the MSN.
2. **Reconsideration by a Qualified Independent Contractor (QIC)** (a contractor that didn't take part in the first decision)**.** Details are included in the redetermination notice.

   Contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal.
3. **Hearing before an Administrative Law Judge (ALJ) (the amount of your claim must meet a minimum dollar amount, which is updated yearly: $130 in 2012)**. Send the request to the ALJ office listed in the reconsideration notice.
4. **Review by the Medicare Appeals Council (MAC).** Details on how to file are included in the ALJ's hearing decision. There is no minimum dollar amount in order to get your appeal reviewed by the Medicare Appeals Council.
5. **Review by a Federal district court.** To get a review by a Federal court, the remaining amount in controversy of your case must meet a **minimum dollar amount, which is updated yearly: $1,350 in 2012**.

NOTE: This chart is available in the corresponding workbook (see Appendix A).



You may ask your doctor for any information that may help your case if you decide to file a fast appeal.

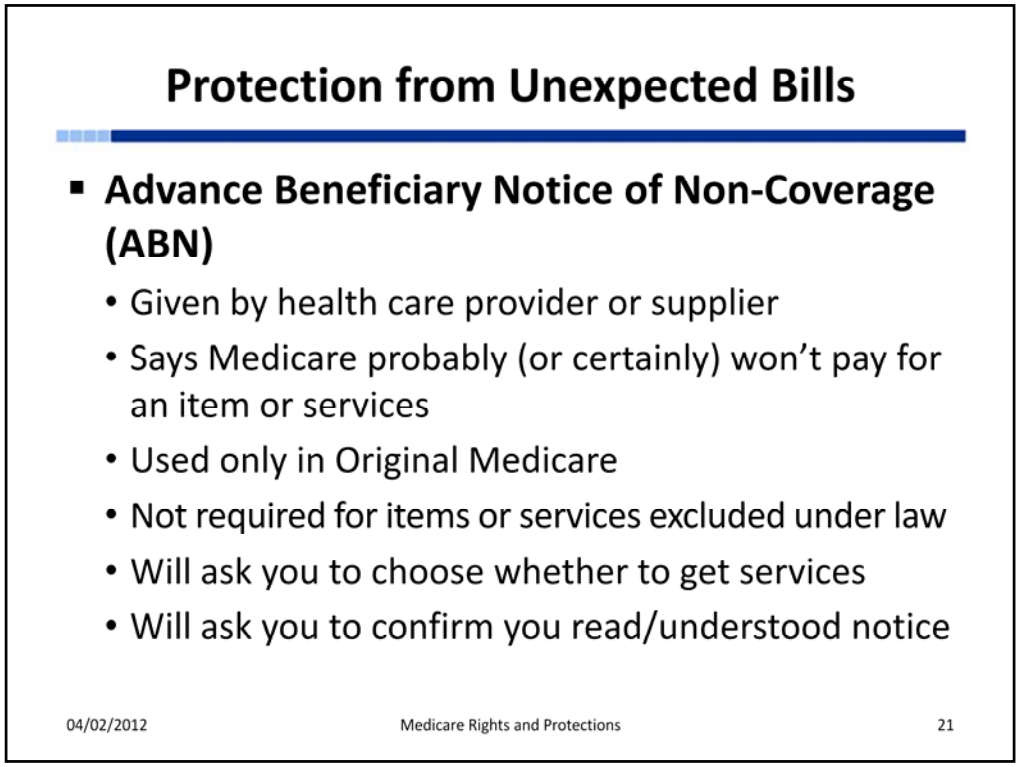
You must call your local QIO to request a fast appeal no later than noon on the day before your notice says your coverage will end.

- The number for the QIO in your state should be on your notice. You can also call 1-800-MEDICARE (TTY users should call 1-877-486-2048).

If you miss the deadline, you still have appeal rights:

- If you have Original Medicare, call your local QIO.
- If you are in a Medicare Advantage plan, call your plan. Look in your plan materials to get the telephone number.

Contact your local SHIP if you need help filing an appeal.



You are protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations he or she will give you a notice that says Medicare probably (or certainly) won't pay for an item or service. This is called an Advance Beneficiary Notice of Noncoverage (ABN). The ABN is used only in Original Medicare for Part B services and Part A services provided by hospices and religious non-medical health institutes.

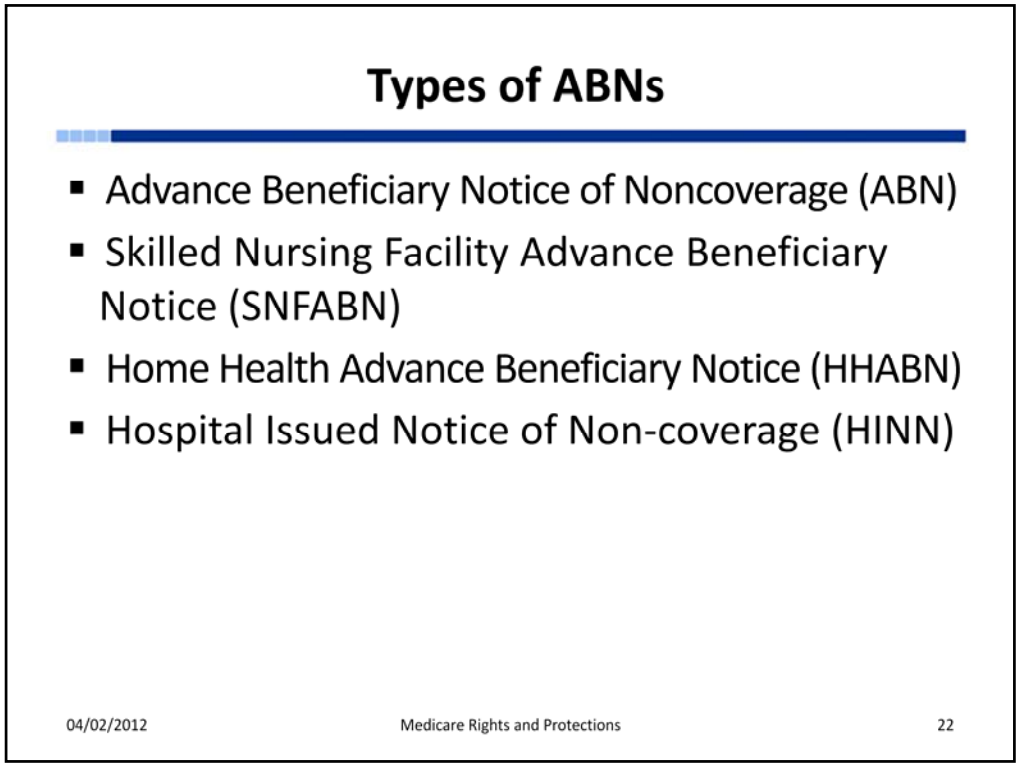
Doctors and suppliers are not required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), such as routine physical exams (except the annual wellness exam), routine eye exams, dental services, hearing aids, and routine foot care; however, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

You may still get the service, you will be asked to choose an option and sign to say that you have read and understand the notice.

If you choose to get the items or services listed on the ABN, you will have to pay if Medicare doesn't. In some cases, the provider may ask for payment at the time the service is received.

Providers (including independent laboratories), physicians, practitioners, and suppliers will use the ABN (Form CMS-R-131) for situations where Medicare payment is expected to be denied because the item or service may not be reasonable and necessary.

NOTE: A copy of the ABN is provided in the corresponding workbook (see Appendix B). It is also available on the web at www.cms.gov/BNI/02_ABN.asp



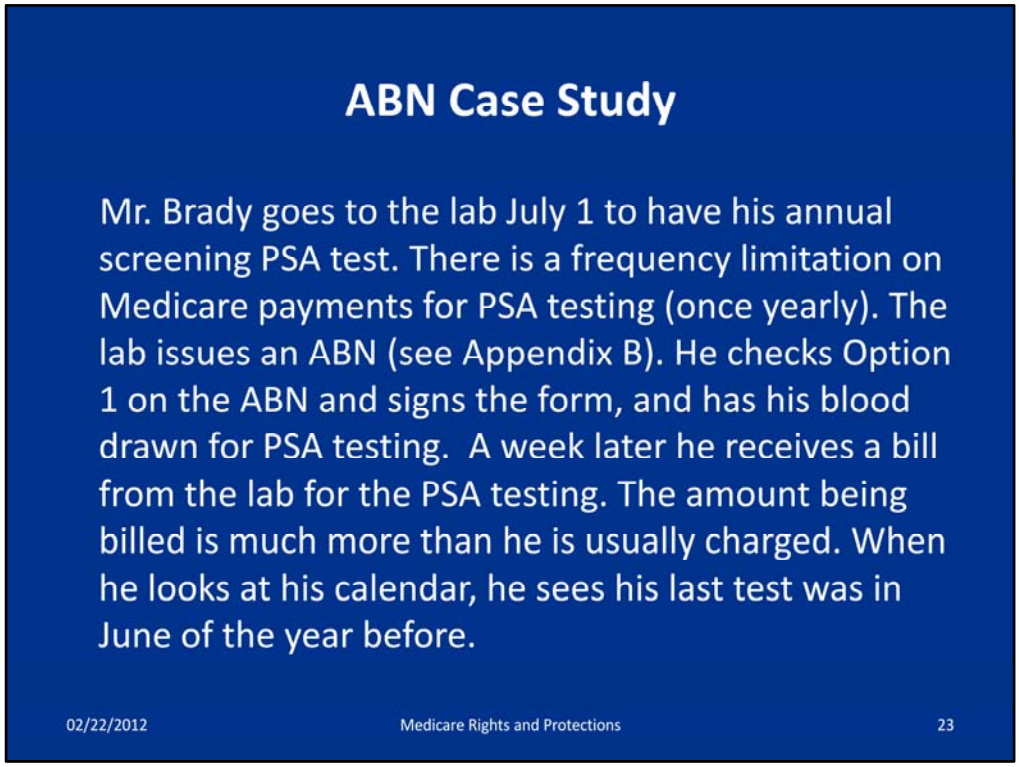
There are four types of ABNs for people with Original Medicare. These notices explain that you may be liable for the cost of certain services under certain conditions. The notices include

- **Advance Beneficiary Notice of Noncoverage (ABN) –** only used for Part B services and for Part A when hospice services or services in a religious non-medical healthcare institute are provided

There are other types of liability notices for people with Original Medicare that are used in specific healthcare settings. Like the ABN, these notices explain that you may be liable for the cost of certain services under certain conditions. These notices include

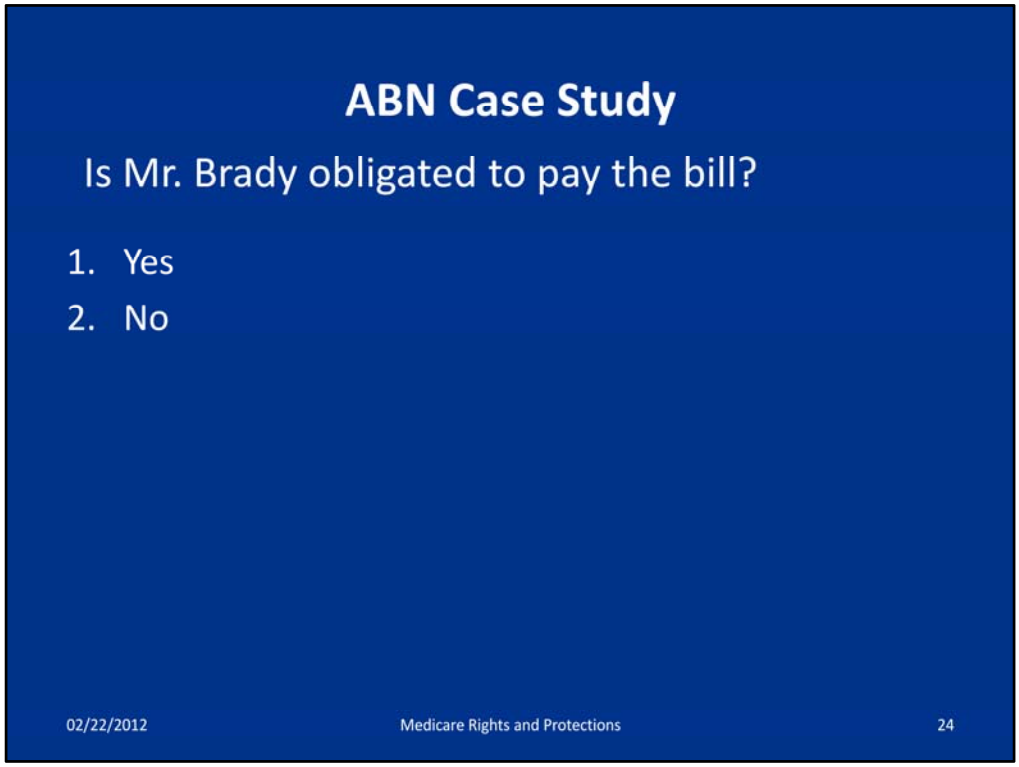
- **Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) -** only used for skilled nursing facility care
- **Home Health Advance Beneficiary Notice (HHABN)** - only used by home health agencies
- **Hospital Issued Notice of Non-coverage (HINN)** - used for inpatient hospital care when the hospital thinks Medicare may not pay for some or all of your care

You can view or print beneficiary notices at www.cms.gov/BNI/.



ABN Case Study

Mr. Brady goes to the lab July 1 to have his annual screening PSA test. There is a frequency limitation on Medicare payments for PSA testing (once yearly). The lab issues an ABN. He checks Option 1 on the ABN and signs the form, and has his blood drawn for PSA testing. A week later he receives a bill from the lab for the PSA testing. The amount being billed is much more than he is usually charged. When he looks at his calendar, he sees his last test was in June of the year before.

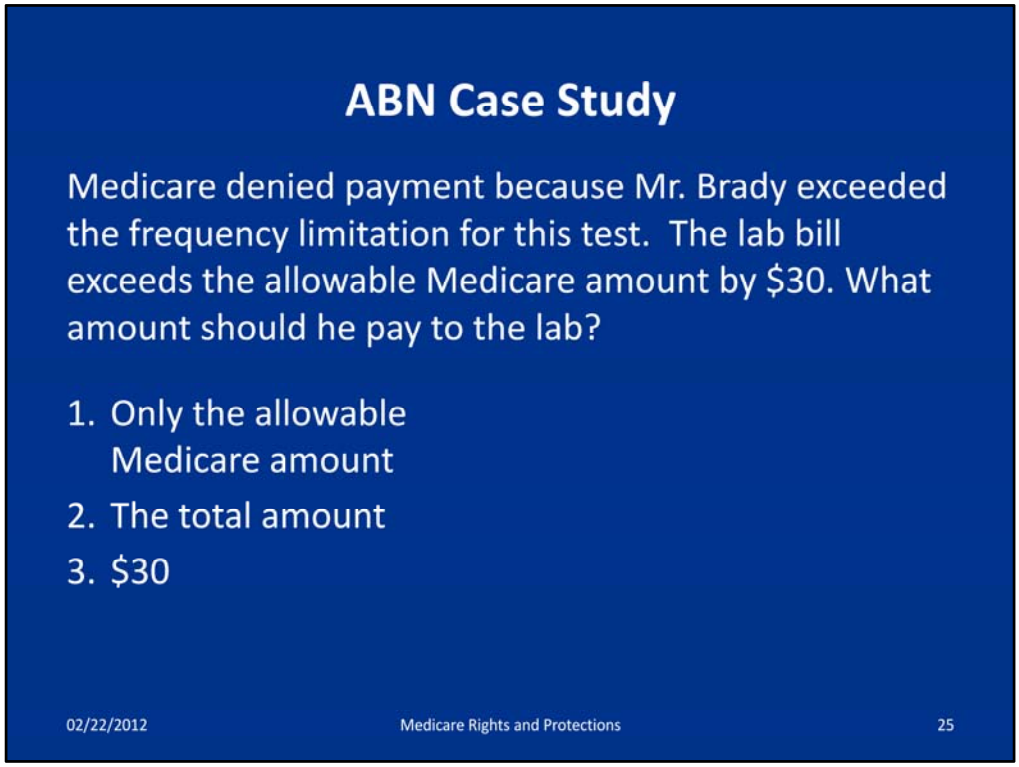


Is Mr. Brady obligated to the pay bill?

Answer: 1. Yes

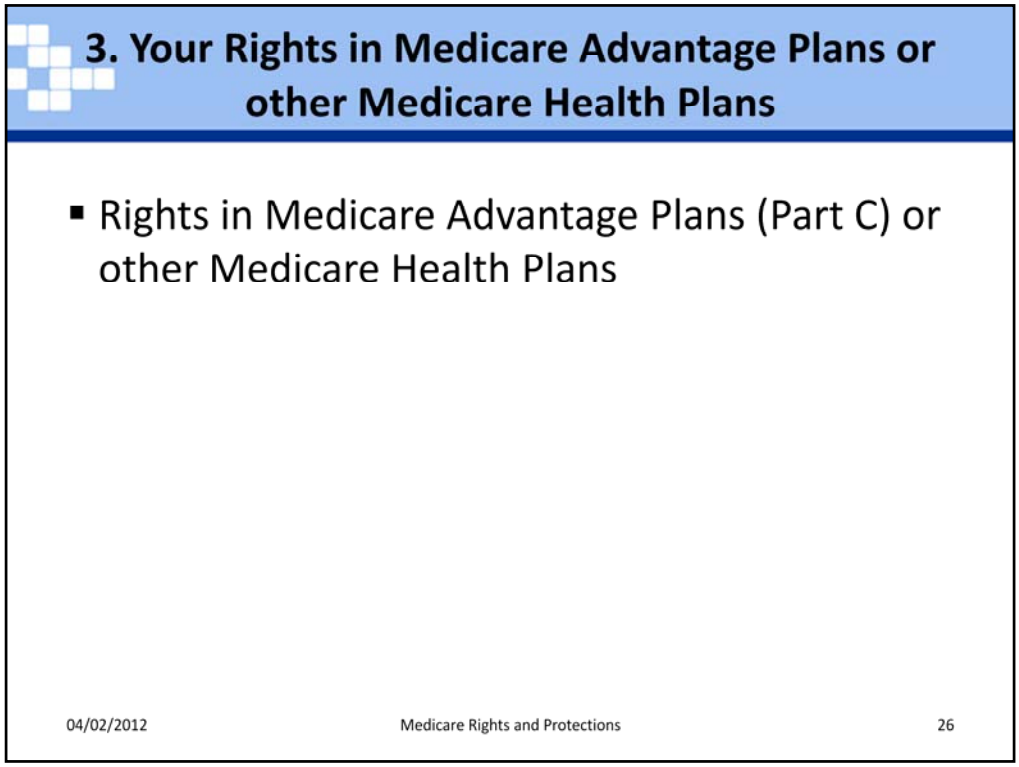
By checking Option 1, He asserted that he wanted the service, wanted the physician to bill Medicare, and agreed to pay for the item/service up front.

The PSA test falls under frequency limitation for screening tests – so an ABN is appropriate. The beneficiary chose Option 1 which obligates him to pay the lab whether Medicare covers the test or not, and obligates him to pay in advance of Medicare's coverage decision as the lab is allowed to charge him for the test up front. Since choosing Option 1 requires the lab to submit a claim to Medicare on Mr. Brady's behalf, the lab should refund any payments made by him if Medicare covers the test.

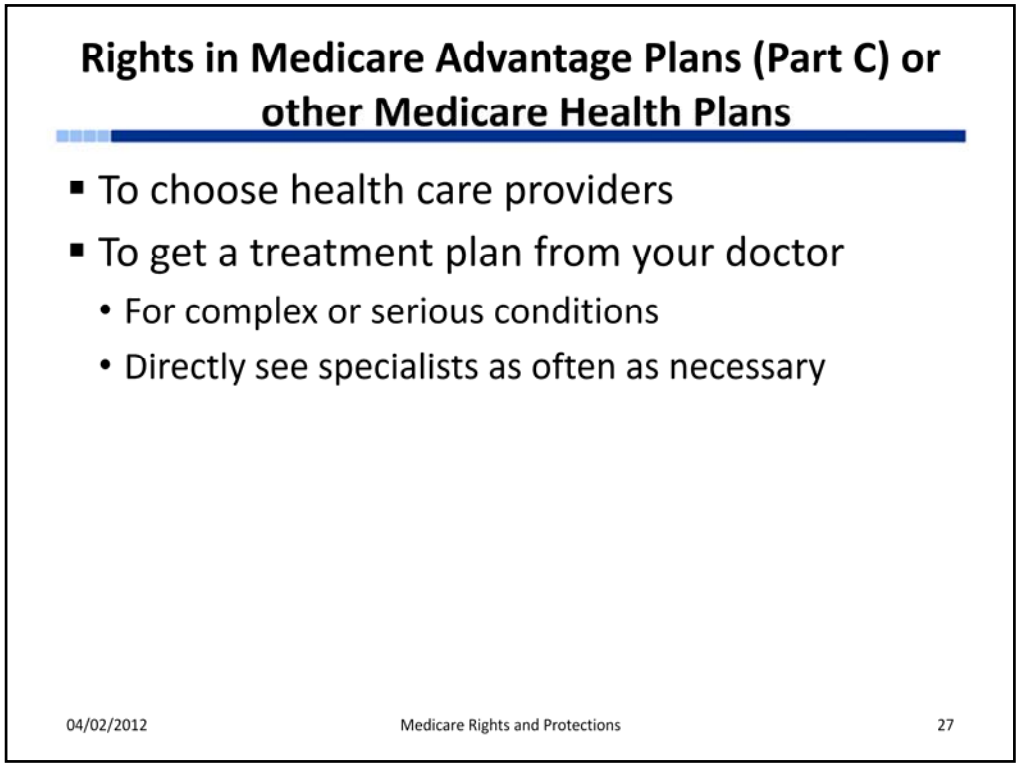


Answer: B (the entire amount the lab billed Mr. Brady for the PSA, which could be the usual and customary fee for non-Medicare patients).

Since the service is not covered by Medicare, charges are not limited to Medicare allowable amounts (i.e. limiting charge), the lab may charge the beneficiary the usual and customary amount for non-Medicare patients.

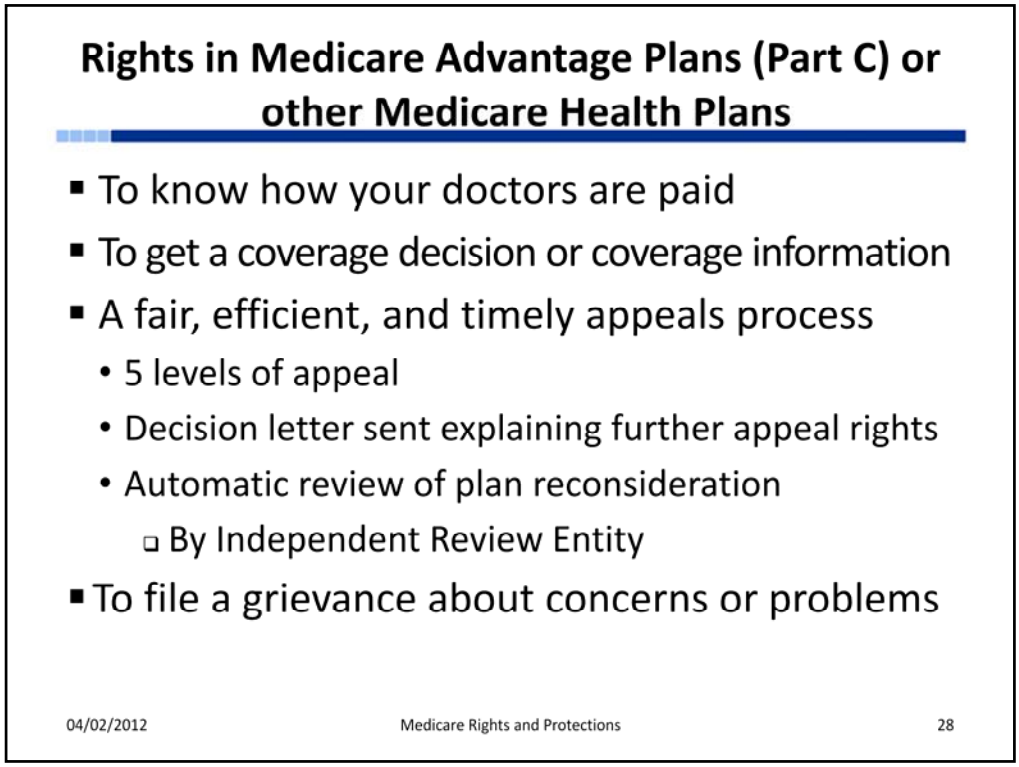


In addition to the rights described in the first section, you have additional rights when you are enrolled in a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan.



If you're in a Medicare health plan, in addition to the rights and protections previously listed in the first section, you have the right to

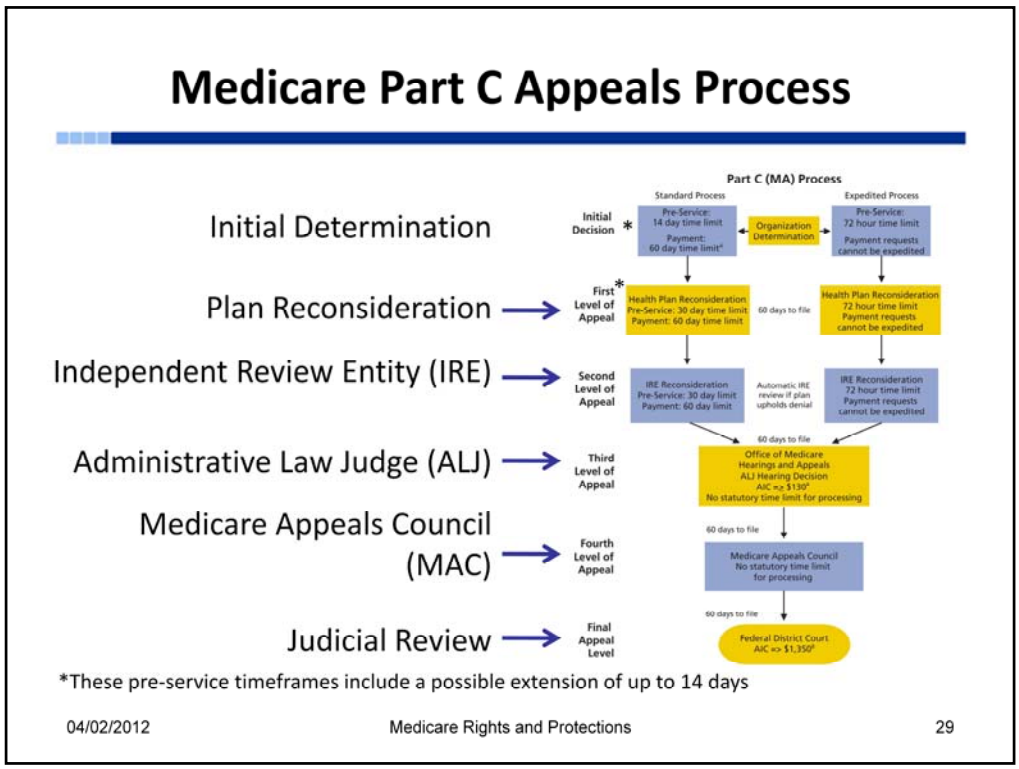
- Choose health care providers within the plan, so you can get health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medial condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.



If you're in a Medicare health plan, in addition to the rights and protections previously in the first section, you have the right to

- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Before you get a service or supply, you can call your plan to find out if it will be covered or get information about your coverage rules.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
  - The appeals process consists of 5 levels
  - If coverage is denied at any appeal level, the enrollee will receive a letter explaining the decision and instructions on how to proceed to the next appeal level
  - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C Independent Review Entity (IRE)
  - File a grievance about other concerns or problems with your plan. Check your plan's membership materials, or call your plan to find out how to file a grievance.
  - Get a coverage decision or coverage information from your plan before getting services.

See *Medicare Rights & Protections (CMS Publication #10112)* for more details.



This chart shows the appeal process for Medicare Advantage Plan or other Medicare health plan enrollees. The time frames differ depending on whether you are requesting a standard appeal, or if you qualify for an expedited (fast) appeal.

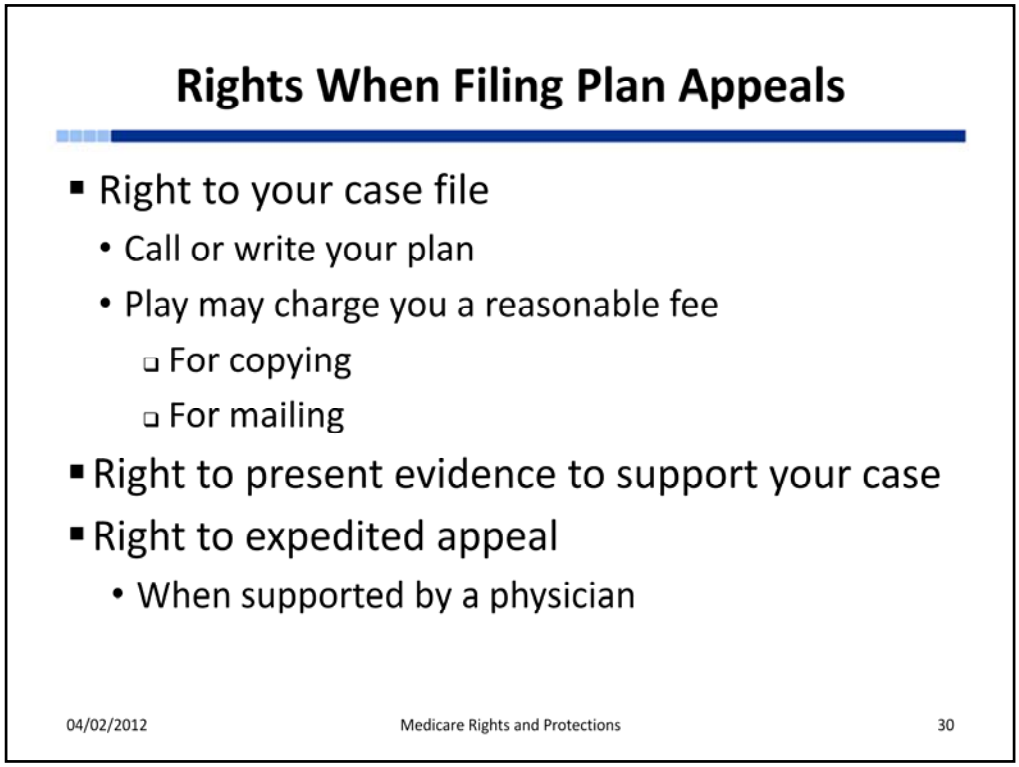
If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You will get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

After each level, you will get instructions on how to proceed to the next level of appeal. The five levels are of appeal are

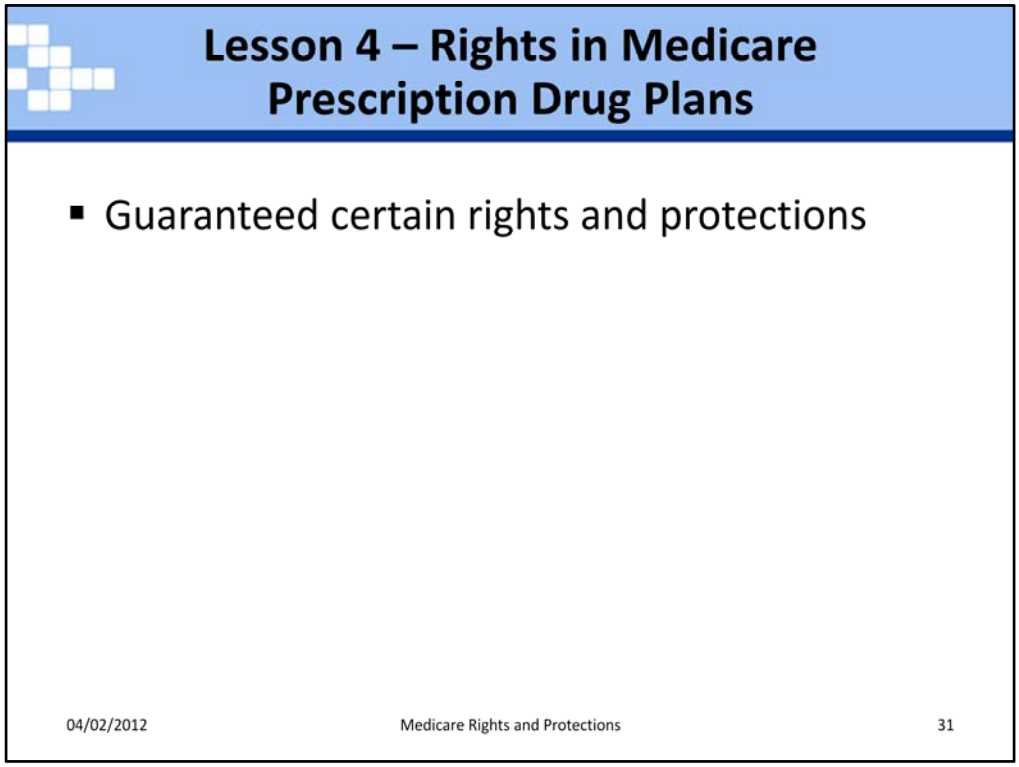
- Reconsideration by the plan
- Reconsideration by the Independent Review Entity (IRE)
- Hearing with the Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Review by a Federal district court

NOTE: This chart is available as a handout in the corresponding workbook (see Appendix C).

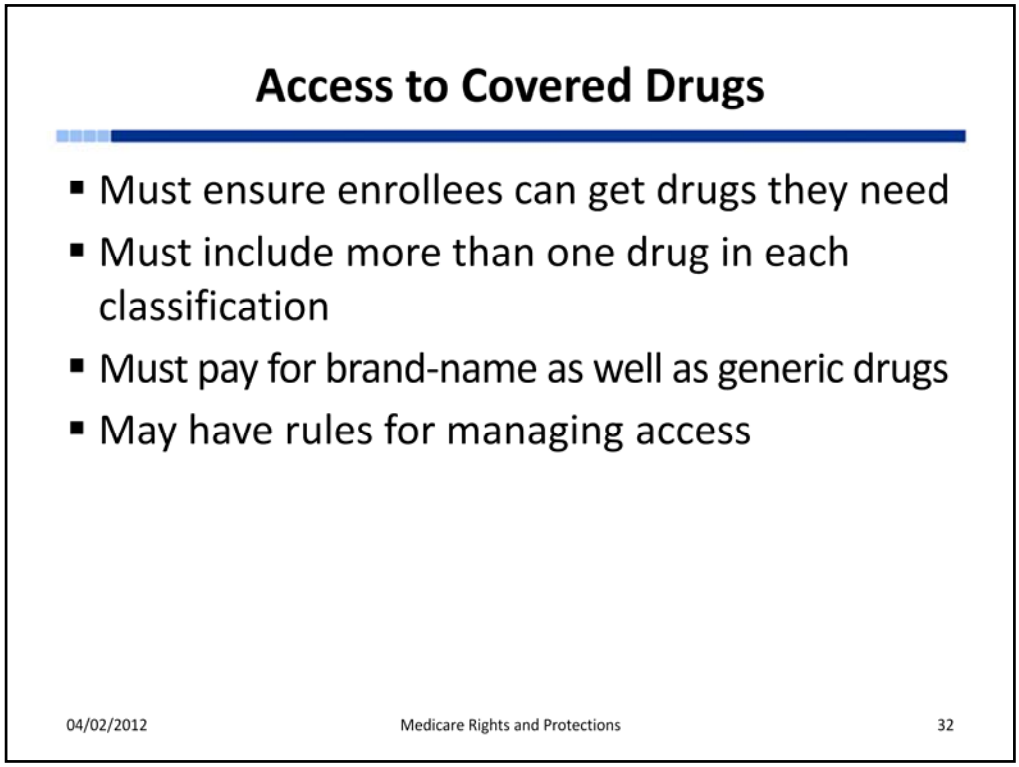


If you are in a Medicare Advantage or other Medicare health plan and you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your *Evidence of Coverage*, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages in the file, plus normal mail delivery.



Lesson 4 explains your rights in Medicare Prescription Drug Plans.



Medicare drug plans work to provide people with Medicare high-quality, cost-effective drug coverage. Medicare drug plans must ensure that their enrollees can get medically-necessary drugs to treat their conditions.

Each plan has a list of covered drugs called a formulary.

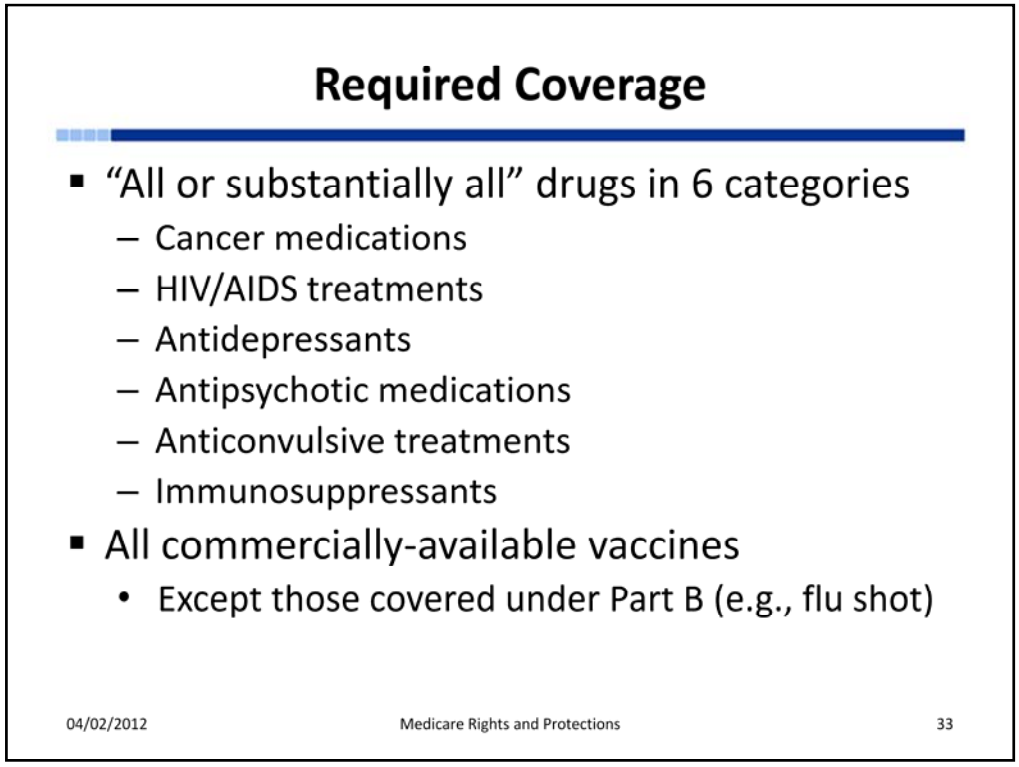
A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Plans must pay for both brand-name and generic drugs.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze are also covered.

Some of the methods that plans use to manage access to certain drugs include

- Formularies
- Prior authorization
- Step therapy
- Quantity limits



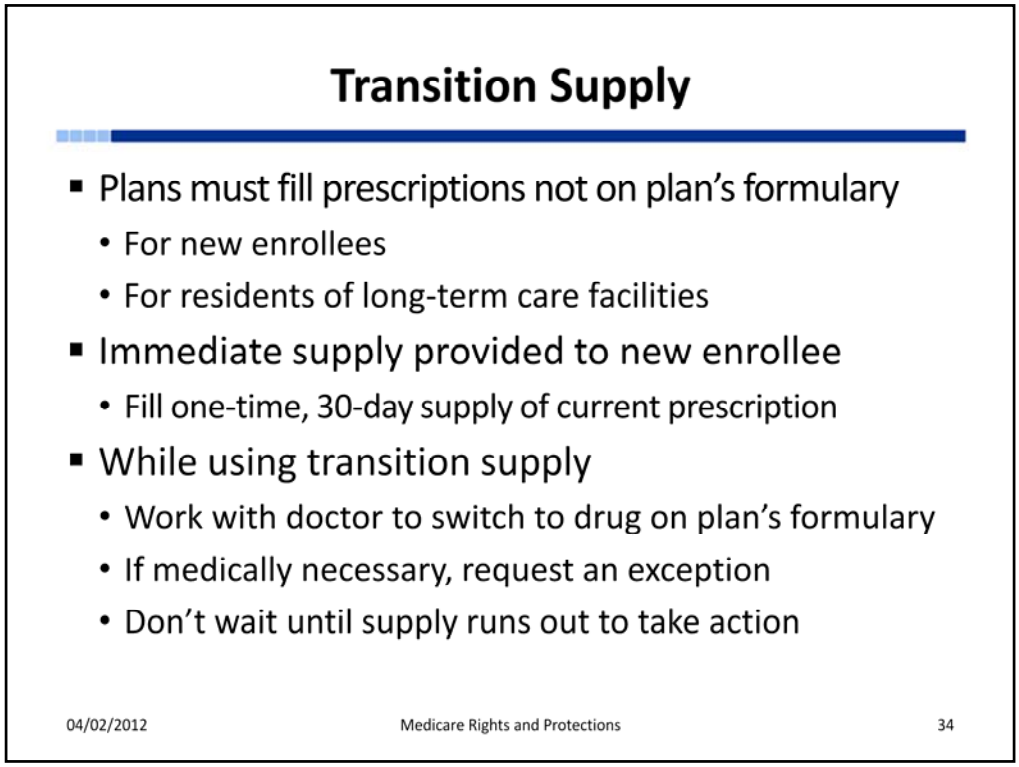
Medicare drug plans must cover "all or substantially all" drugs in 6 categories to treat certain conditions, including

- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine (but not vaccines such as the flu and pneumococcal pneumonia shots that are covered under Part B).

You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

NOTE: Please see Appendices A - C for a list of oral anti-cancer drugs, oral anti-emetics prescribed for use within 48 hours of chemotherapy, and immunosuppressive drugs.



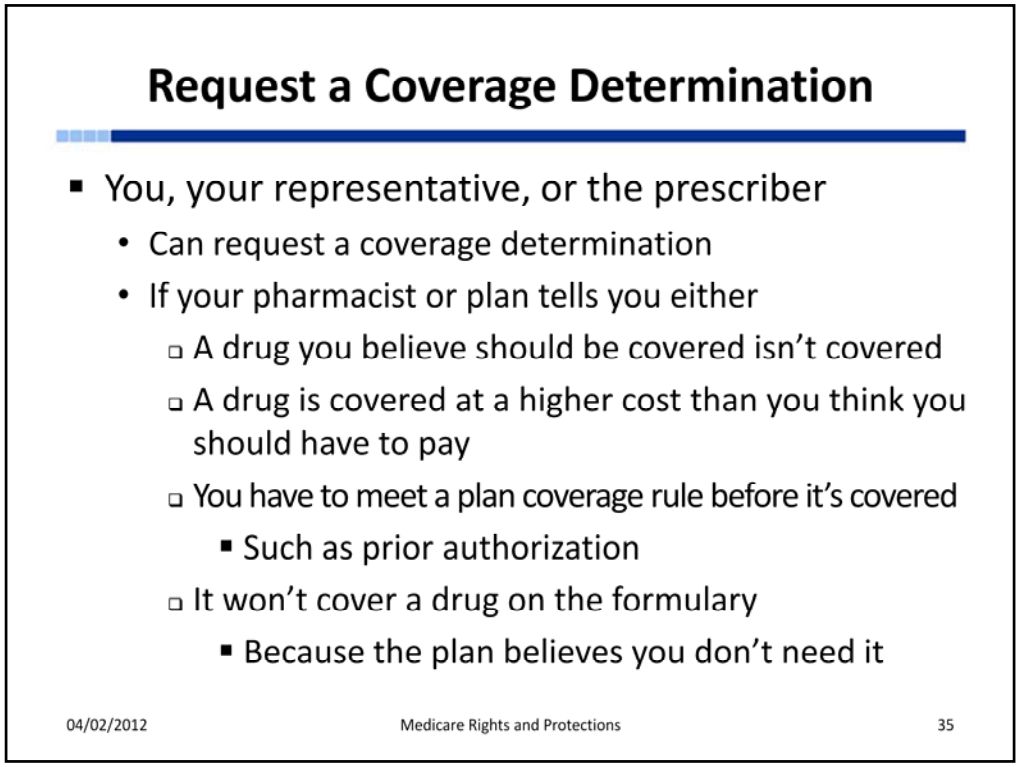
Some new members may already be taking a drug that's not on their plan's drug list or that is a step therapy drug. Medicare requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs, even if the prescription is for a drug that's not on the plan's drug list, is a step-therapy drug, or requires prior authorization. This gives you and your doctor time to find another drug on the plan's drug list that would work as well. However, if you have already tried similar drugs and they didn't work, or if the doctor believes that because of your medical condition you must take a certain drug, the doctor can contact the plan to request an exception to the formulary rules. If the doctor's request is approved, the plan will cover the drug. If the exception is not granted, you can file an appeal.

It is important to understand how to work with your plan's formulary and to plan ahead. If you receive a transition supply, you shouldn't wait until that supply is gone to take action. You should talk to your doctor about

- Prior authorization (if necessary)
- Safe and effective alternative drugs that may also save you money
- Requesting an exception, if necessary for your condition

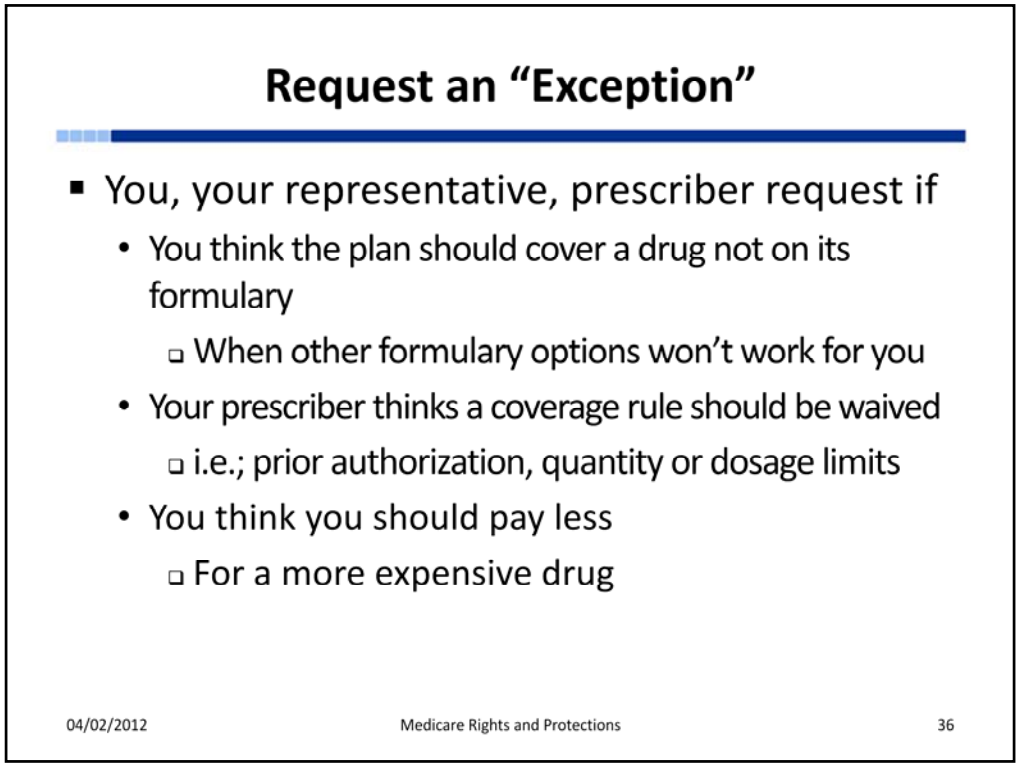
You should contact your drug plan with any questions about what is covered by the plan.

NOTE: In most cases with step therapy drugs, the plan member must first try certain less-expensive drugs that have been proven effective for most people with that condition.



You, your representative, your doctor, or other prescriber can request (orally or in writing) that your plan cover the prescription you need. You can request a coverage determination (either before or after you receive the drug) if your pharmacist or plan tells you one of the following

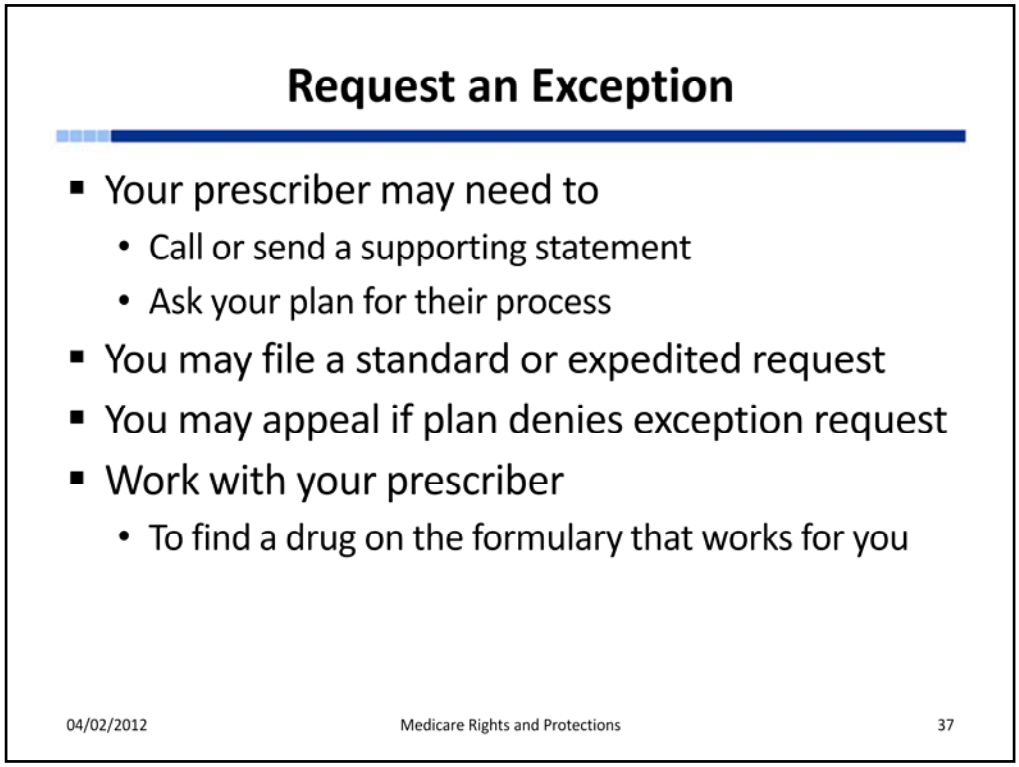
- A drug you believe should be covered isn't covered.
- A drug is covered at a higher cost than you think you should have to pay.
- You have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested.
- It won't cover a drug on the formulary because the plan believes you don't need the drug.



You, your representative, your doctor, or other prescriber can request a coverage determination called an "exception" if:

- You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you.
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules, such as prior authorization, step therapy, or quantity or dosage limits.
- You think your plan should charge a lower amount for a drug you're taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.

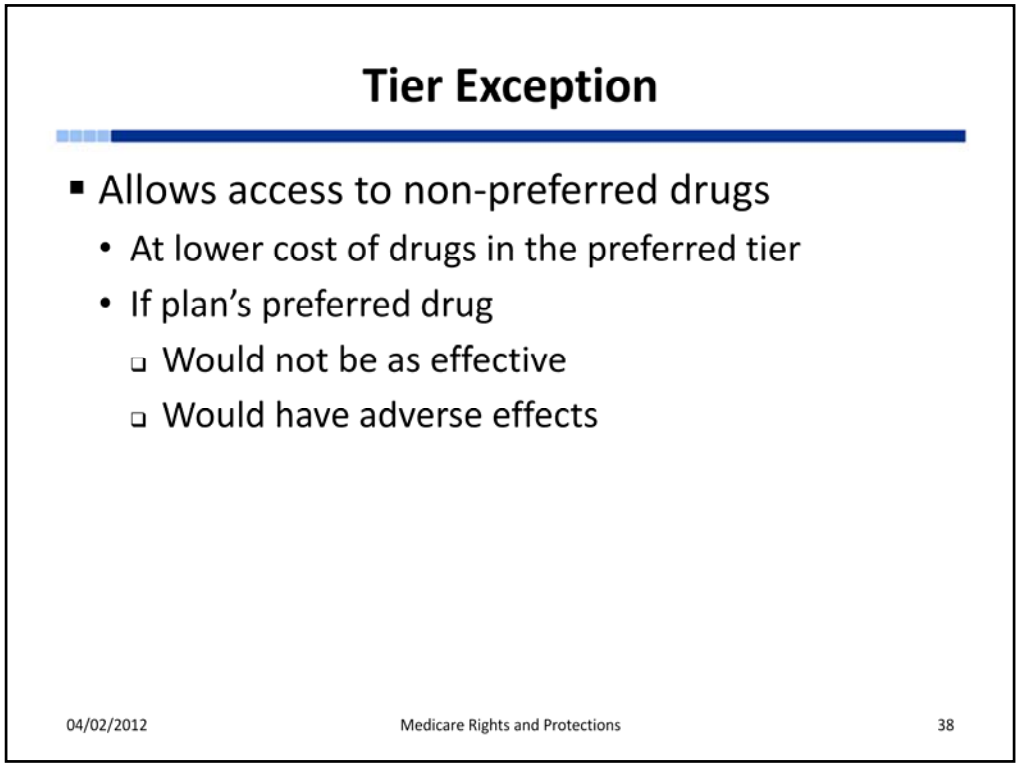
If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required and if it must be made in writing. The plan's decision-making time period begins once your plan gets the supporting statement.



To request a coverage determination called an "exception," your doctor or other prescriber may need to call or send your plan a supporting statement explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required and if it must be made in writing. If a supporting statement is required, the plan's decision-making time period begins once your plan gets the supporting statement.

You may file a standard or expedited (fast) request.

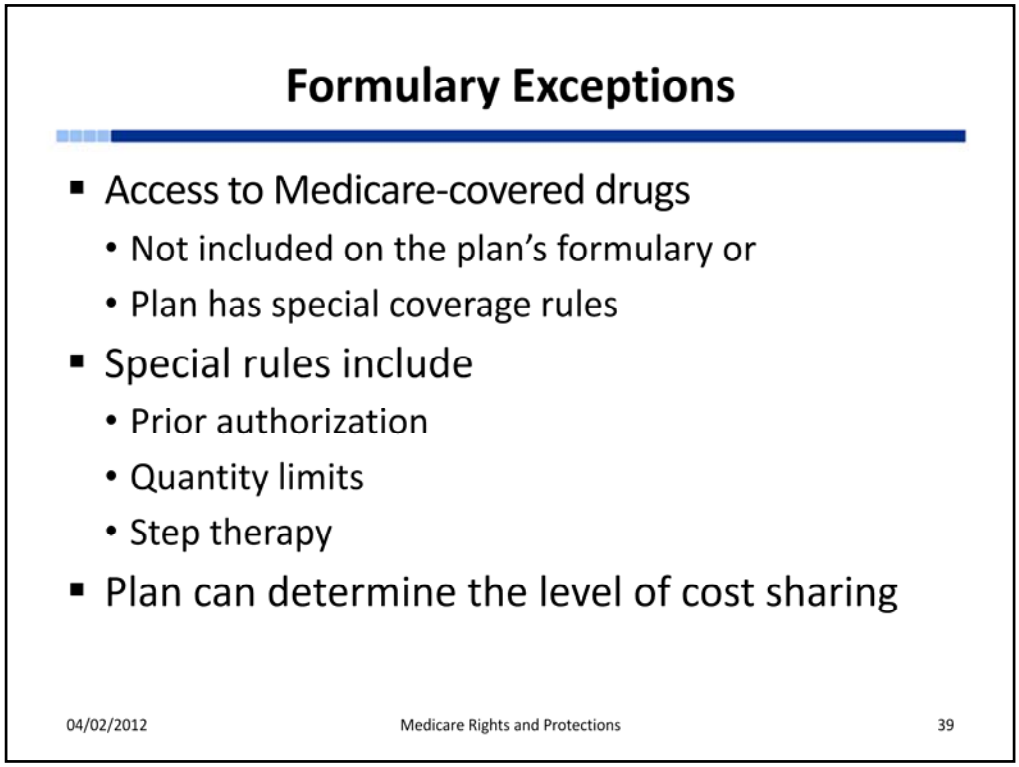
If you disagree with the decision, you have the right to appeal.



If a plan uses a tiered cost-sharing structure to manage its Medicare drug benefit, it must provide exceptions procedures that permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing level for drugs in the preferred tier.

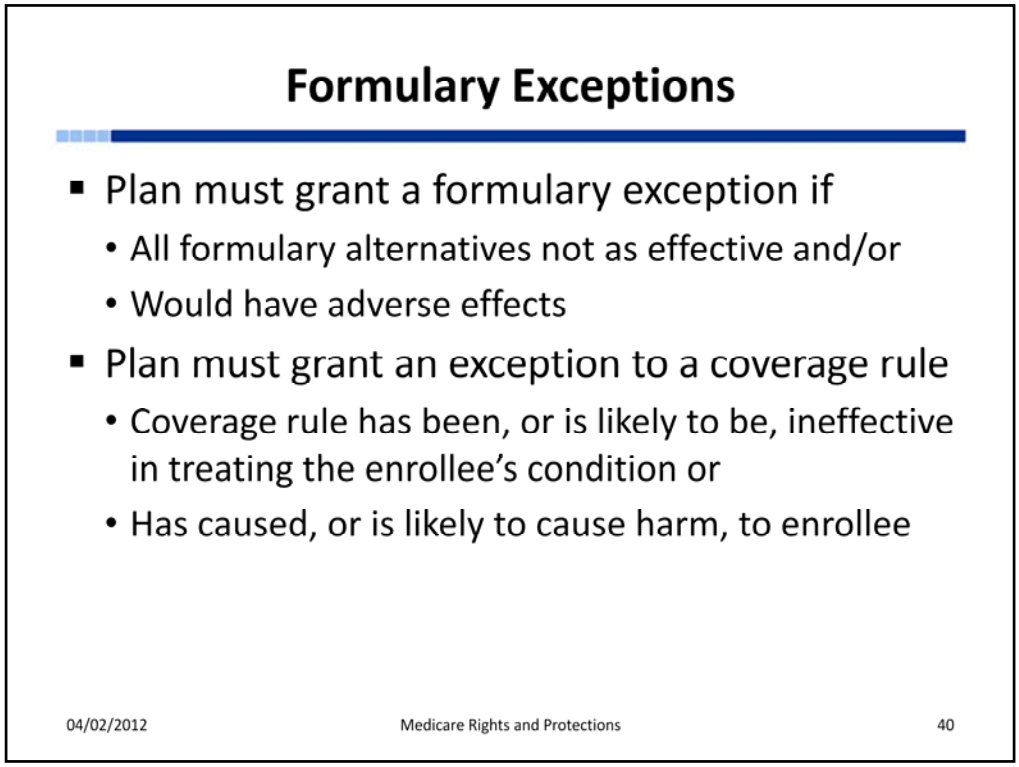
A plan must grant a tier exception when it determines that the preferred drug for treatment of your condition would not be as effective for you as the requested drug and/or it would have adverse effects.

When a tier exception is approved, the plan must provide coverage at the cost-sharing level that applies for preferred drugs, but not at the generic cost-sharing level. Also, if a plan maintains a formulary tier in which it places very high cost and unique items, it may design its exception process so that drugs placed in that tier are not eligible for a tier exception.



Formulary exceptions ensure enrollees have access to Medicare-covered drugs that are not included on the plan's formulary or for which the plan has special coverage rules. These special rules include prior authorization, quantity limits, and step therapy.

When a formulary exception is approved, the plan has the flexibility to determine the level of cost sharing that will apply for the non-formulary drug(s). For example, a plan sponsor may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.



A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or would have adverse affect. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused, or is likely to cause harm, to the enrollee.

If an exception request is approved, the exception is valid for refills for the remainder of the plan year, so long as

- The member remains enrolled in the plan,
- The physician continues to prescribe the drug, ***and***
- The drug remains safe for treating the person's condition.

A plan may choose to extend coverage into a new plan year. If it does not, it must provide written notice to the member either at the time the exception is approved, or at least 60 days before the plan year ends. The written notice must tell the member about the date coverage will end, the right to request a new exception, and the process for making a new exception request. If coverage isn't extended, the member should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during the Medicare Open Enrollment Period "also known as Open Enrollment."

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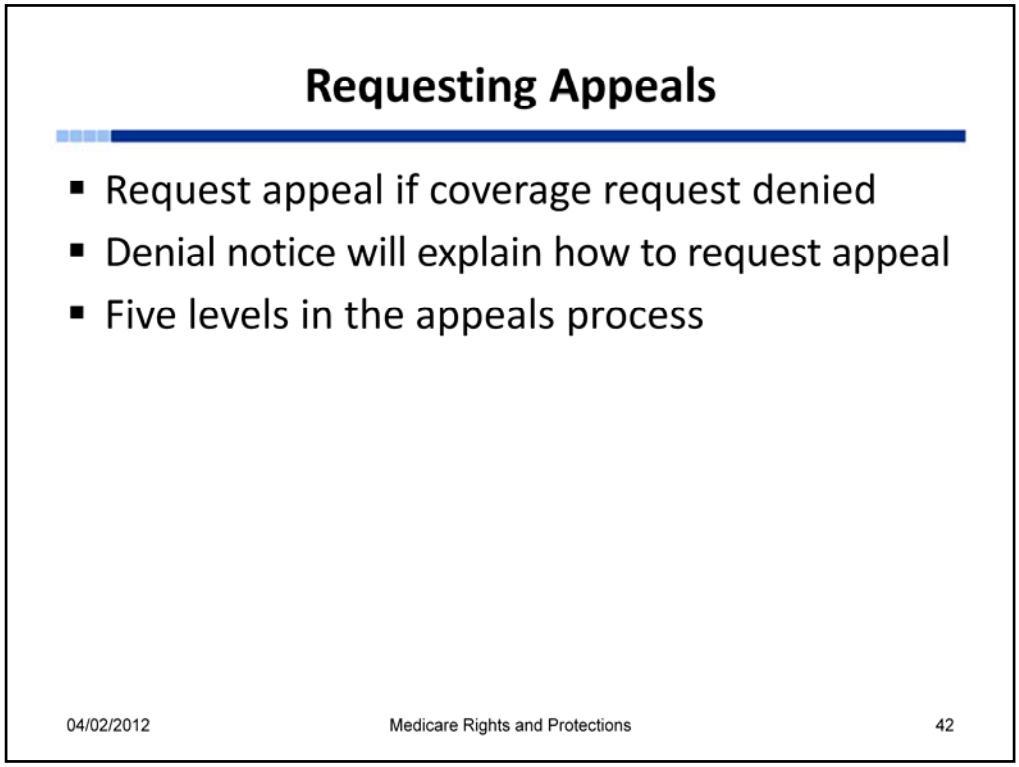
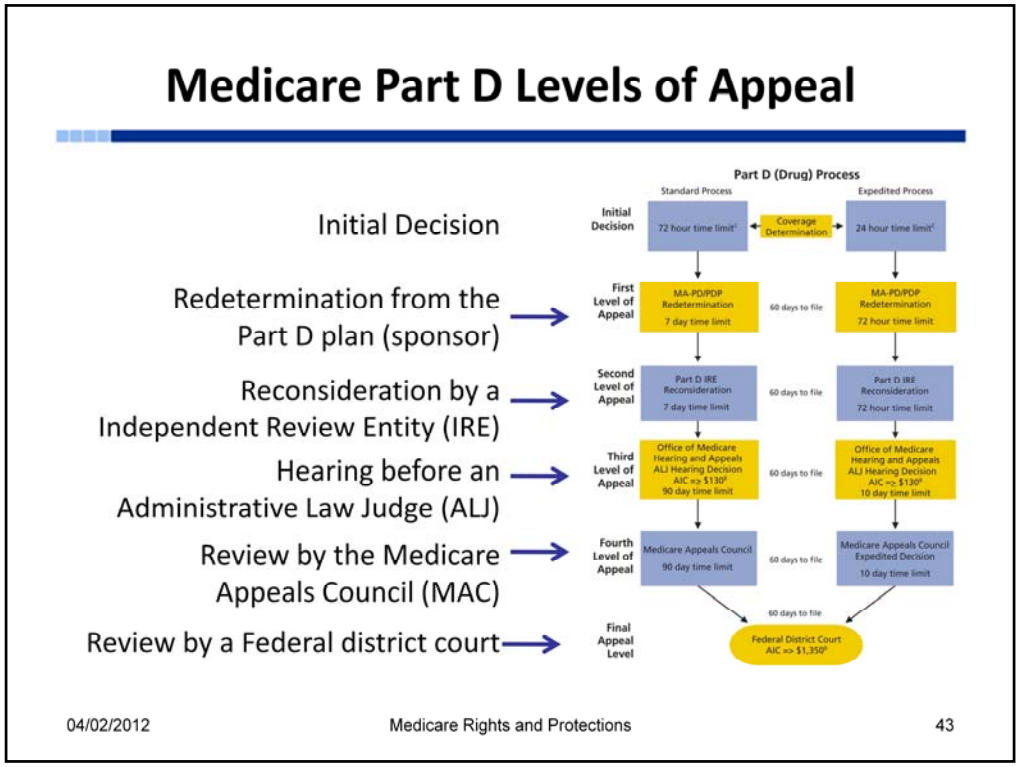


When requesting appeals

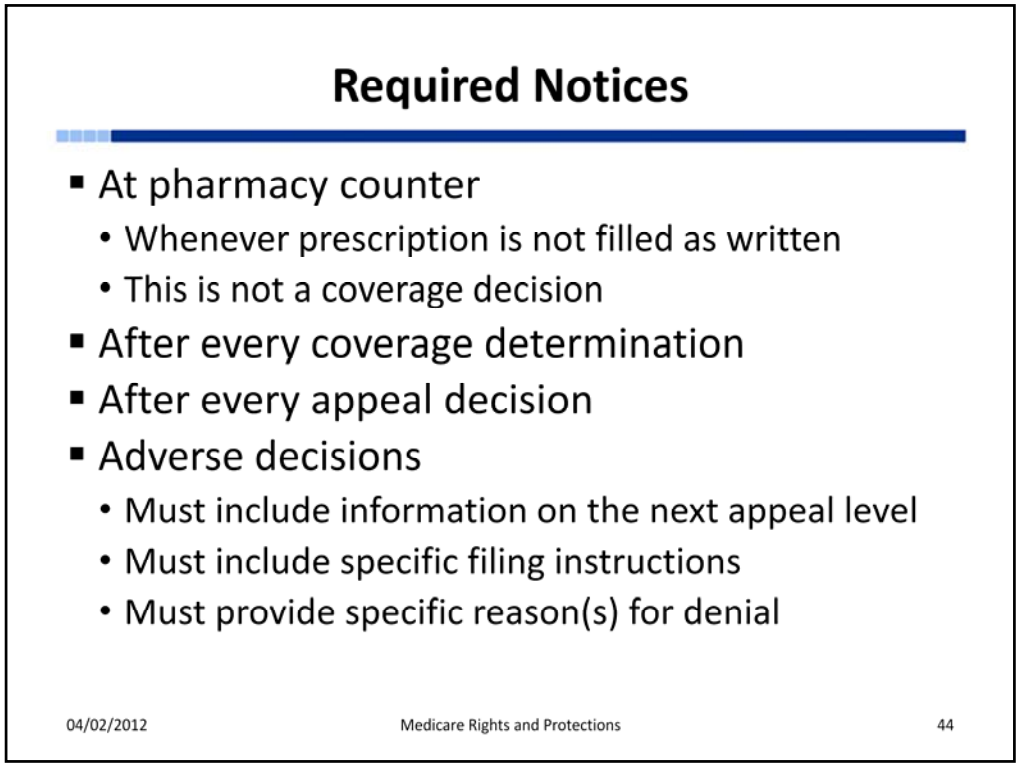
- Request an appeal if your coverage determination request is denied.
- The denial notice will explain how to request an appeal and the process for requesting the appeal.
- There are five levels of appeal in the appeals process.



If you receive an unfavorable initial decision, you have the right to appeal the decision. There are 5 levels of appeal:

1. Redetermination from the Part D plan (sponsor)
2. Reconsideration by an Independent Review Entity (IRE)
3. Hearing before an Administrative Law Judge (ALJ)
4. Review by the Medicare Appeals Council
5. Review by a Federal district court

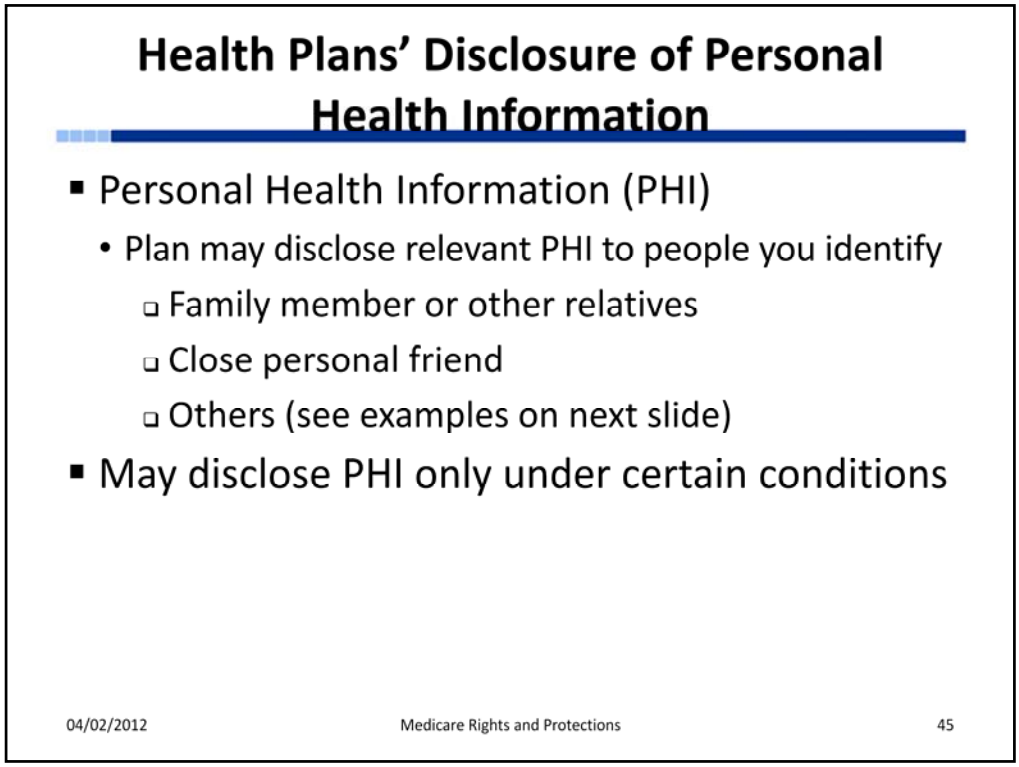
NOTE: This chart is available in the corresponding workbook (see Appendix D).



Plan sponsors must ensure that their network pharmacies provide the Pharmacy Notice whenever a prescription cannot be filled as written.

Plans sponsors are required to provide written notices after every coverage determination or appeal decision.

In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse, the notice will explain the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.



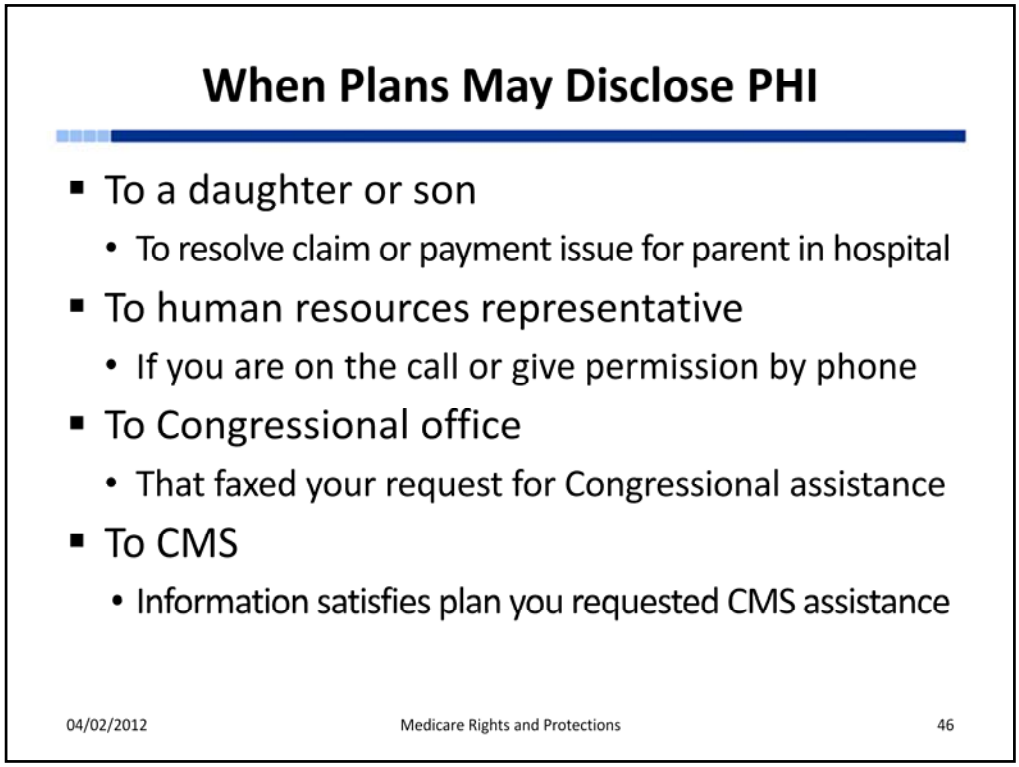
A health-care provider or plan, such as a Medicare drug plan, may disclose relevant protected health information (PHI) to someone who assists you, specifically regarding the drug benefit. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.

Your plan may disclose relevant PHI to those identified by **you** as being involved in your care or payment, including the following:

- Family members or other relatives
- Close personal friends
- Others (see examples on next slide)

Your plan may disclose relevant PHI to those identified by you only under the following conditions:

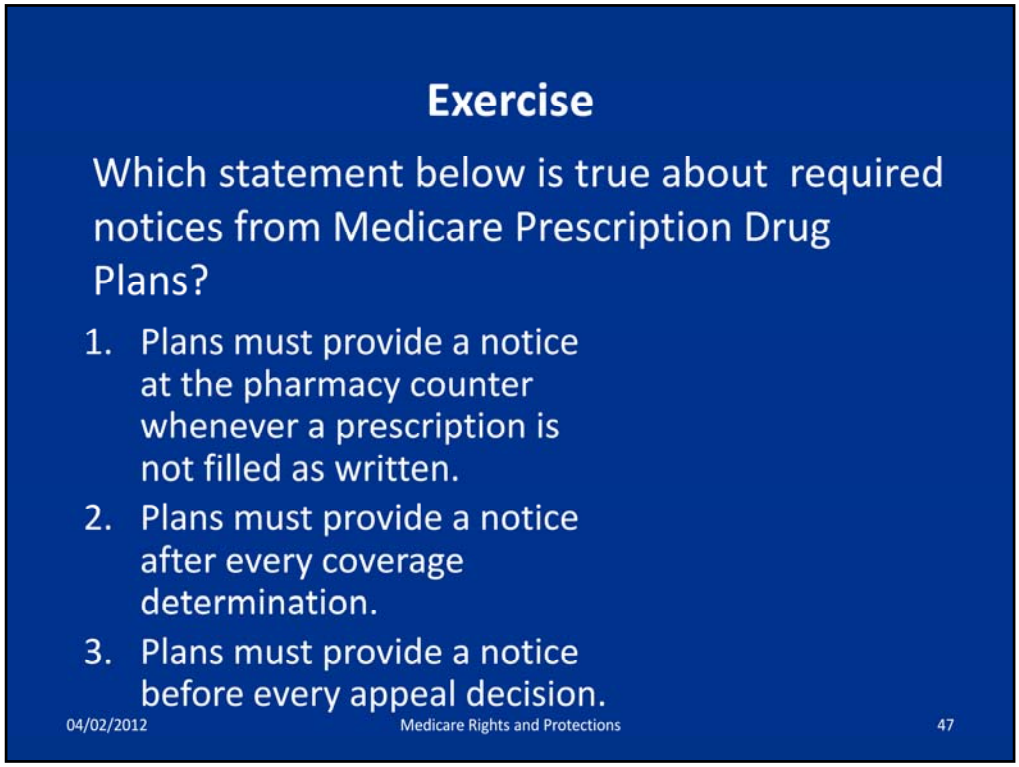
- When you are present and agree or the plan reasonably infers from the circumstances that you do not object;
- When you are not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest.



A plan may disclose Personal Health Information (PHI) to

- The daughter of a person with Medicare who is resolving a claim or payment issue for her hospitalized mother;
- A human resources representative if the person with Medicare is on the line or gives permission by phone;
- A Congressional office or staff person that has faxed the person's request for Congressional assistance;
- CMS staff if the available information satisfies the plan that the individual requested CMS assistance

NOTE: PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services.

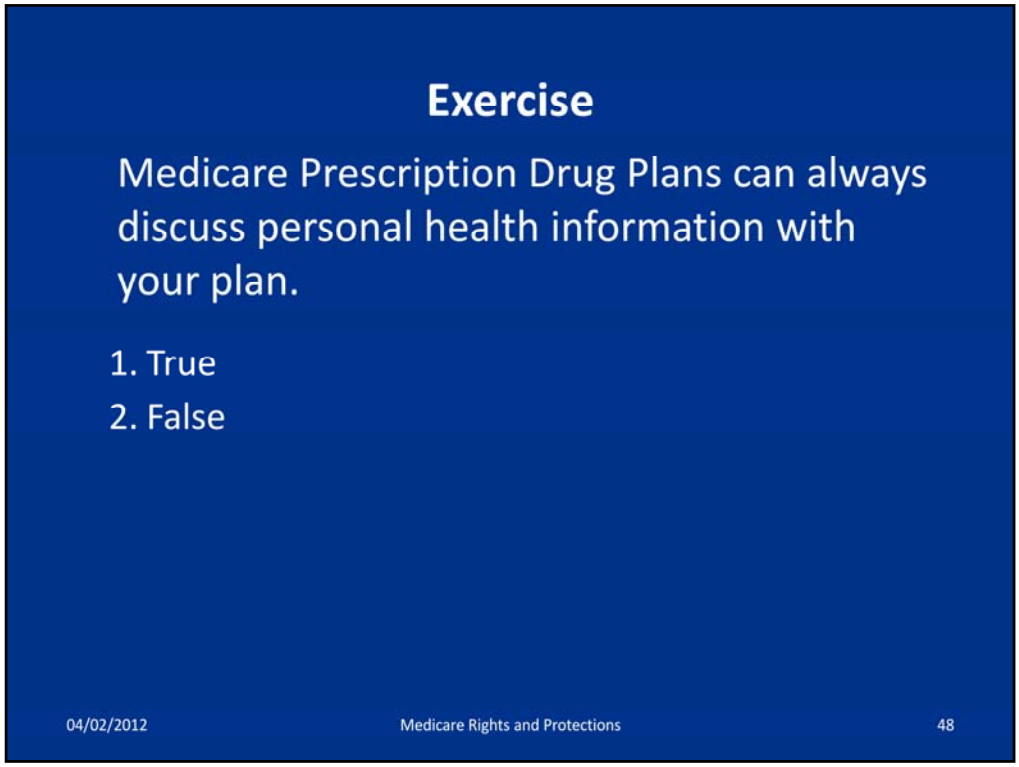


Exercise

Which statement below is true about required notices from Medicare Prescription Drug Plans?

1. Plans must provide a notice at the pharmacy counter whenever a prescription is not filled as written.
2. Plans must provide a notice after every coverage determination.
3. Plans must provide a notice before every appeal decision.

Answer: 2. Plans must provide a notice after every coverage determination.



Exercise

Medicare Prescription Drug Plans can always discuss personal health information with your plan.

1. True
2. False

Answer: 2. False.
Medicare Prescription Drug Plans may only talk to human resources representatives about personal health information if you are on the call or give permission by phone.

Lesson 5 explains your guaranteed rights when admitted to a hospital or skilled nursing facility, or you are receiving care from a non-institutional provider, such as home health, hospice, or a comprehensive outpatient rehabilitation facility (CORF).

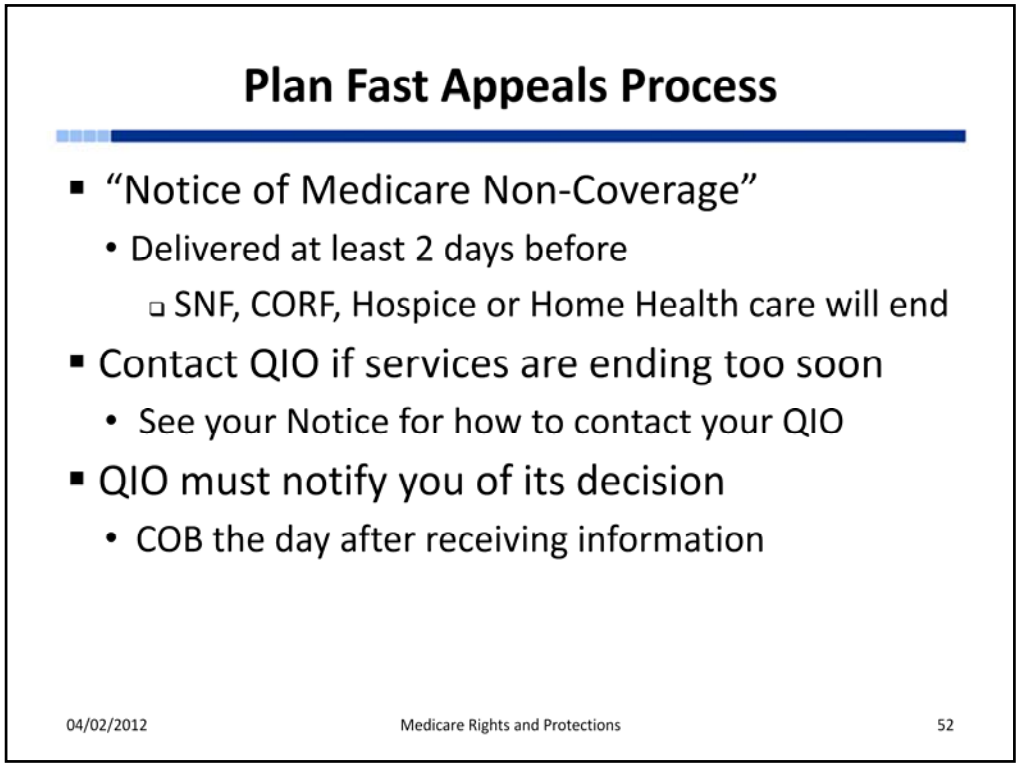
Many of these rights and protections are the same whether you are in Original Medicare, Medicare Advantage Plan (like an HMO or PPO), or other Medicare health plan.

All people with Medicare, including those in Medicare Advantage or other Medicare health plans, have the right to get all of the Medicare-covered hospital care they need to diagnose and treat their illness or injury, including any follow-up care they need after leaving the hospital.

When admitted to the hospital as an inpatient, you will receive a notice called an *Important Message From Medicare About Your Rights* and the hospital must provide you with a copy of the notice so that you know your rights as a hospital inpatient.

The "Important Message from Medicare" is a notice you receive after being admitted to the hospital. This notice is signed by you and a copy is provided to you explaining your rights to

- Get all medically-necessary hospital services
- Be involved in any decisions
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal



With the Medicare Health Plan Fast Appeals Process:

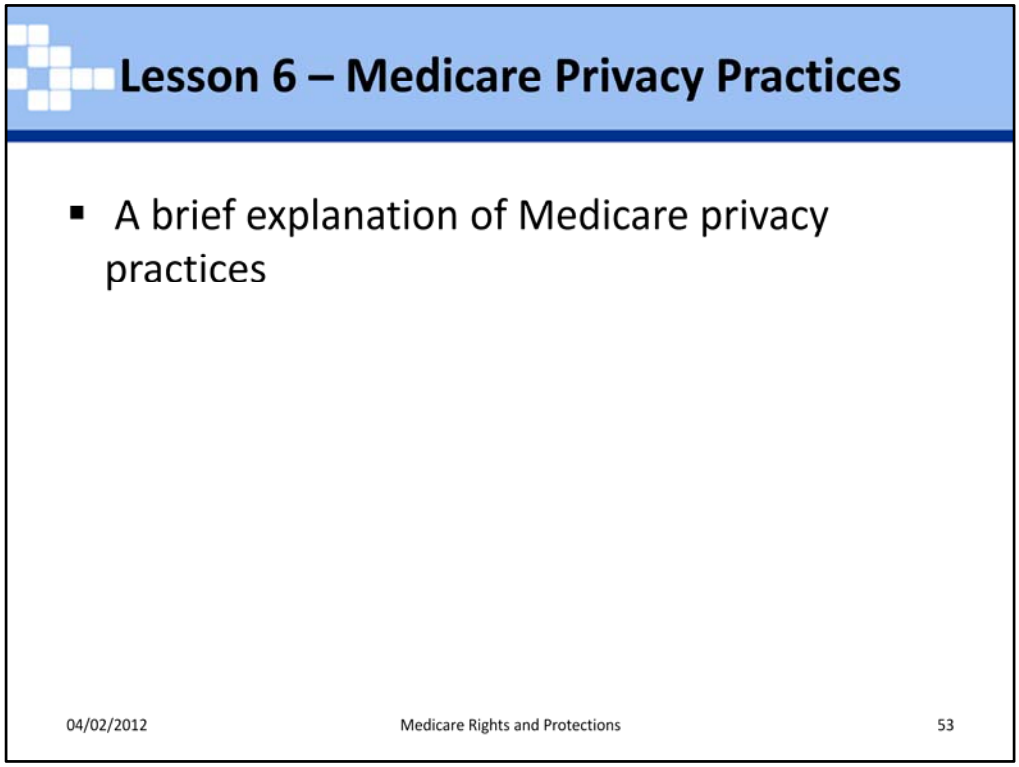
- You have the right to ask the Quality Improvement Organization (QIO) to require your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, or in a comprehensive outpatient rehabilitation facility.
- Your provider must deliver a *Notice of Medicare Non-Coverage* at least 2 days before Medicare-covered SNF, CORF, or HHA care will end.
- If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal.

See your Notice for how to contact your QIO and for other important information.

The QIO must notify you of its decision by close of business of the day after it receives all necessary information.

The plan must give you a *Detailed Explanation of Non-Coverage*. This notice will explain why the coverage is being discontinued.

You have the right to ask for a reconsideration by the QIC (Qualified Independent Contractor) if you are dissatisfied with the results of the fast appeal.



Lesson 6 explains Medicare's privacy practices.

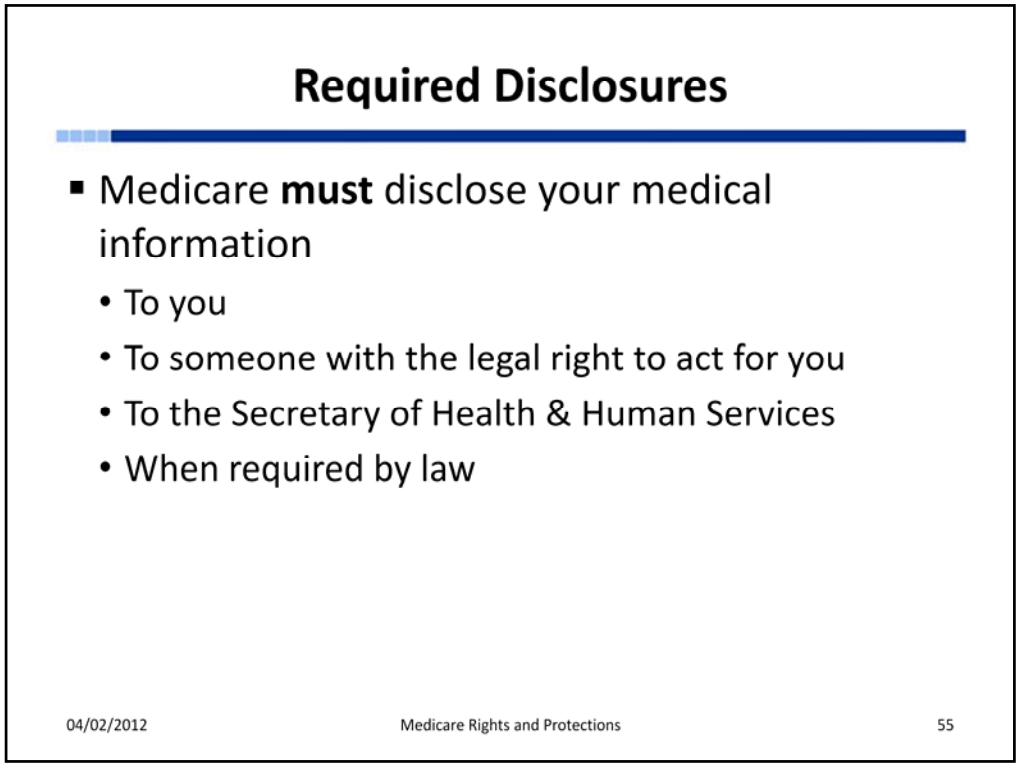
"Notice of Privacy Practices"

- Tells you how Medicare
  - Must protect the privacy of your personal health information
  - Uses and discloses your personal medical information
- Describes your rights and how you can exercise them
- Published annually in *Medicare & You* handbook
- For more information
  - Visit www.medicare.gov
  - Call 1-800-MEDICARE (1-800-633-4227)

04/02/2012 Medicare Rights and Protections 54

Medicare is required to protect your personal medical information. The *Notice of Privacy Practices for Original Medicare* describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you are enrolled in a Medicare Advantage Plan or other Medicare plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

- The Notice of Privacy Practices is published annually in the *Medicare &* You handbook.
- For more information, go to medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



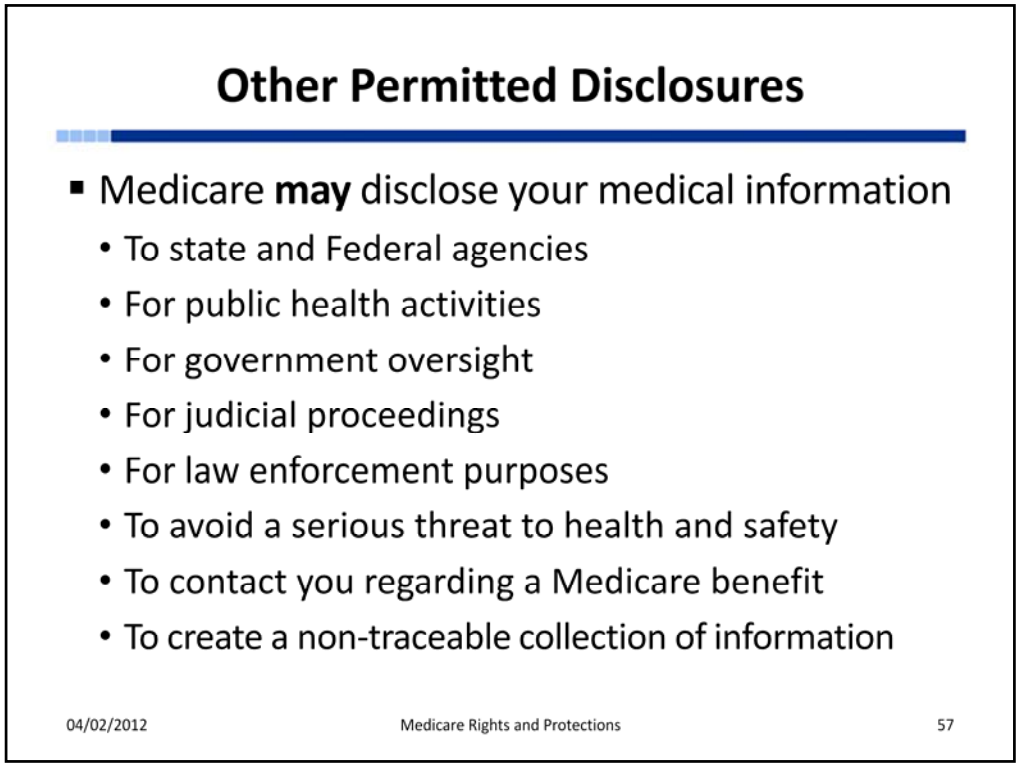
Medicare **must** disclose your personal medical information

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of Health and Human Services, if necessary, to make sure your privacy is protected
- Where required by law

Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program.

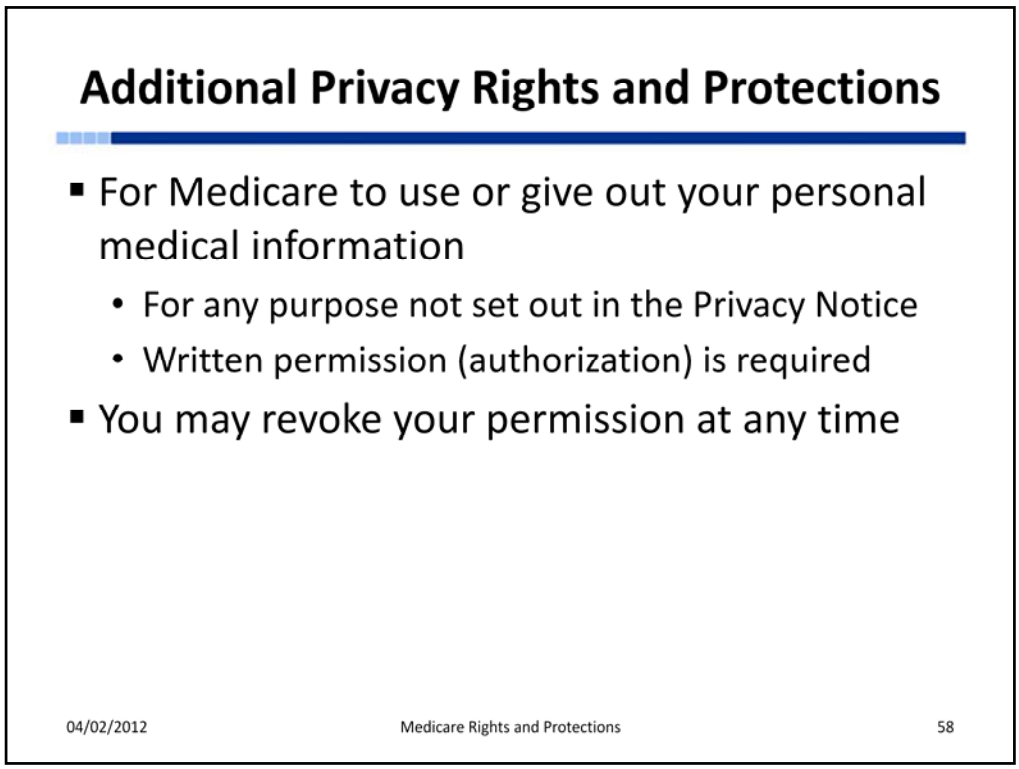
Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your Medicare Summary Notice.

Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer services to you, or to resolve any complaints you have, or to contact you about research studies.

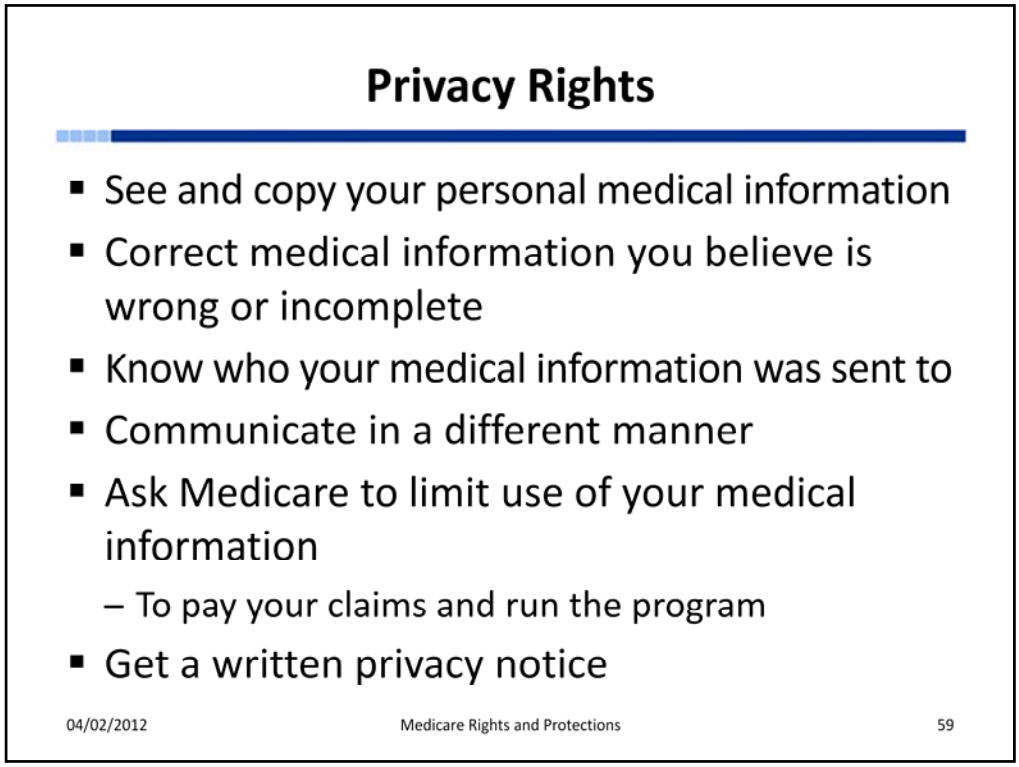


Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances

- To state and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/state Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government health care oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing limited information to locate a missing person)
- To avoid a serious threat to health or safety
- To contact you regarding a new or changed Medicare benefit
- To create a collection of information that can no longer be traced back to you

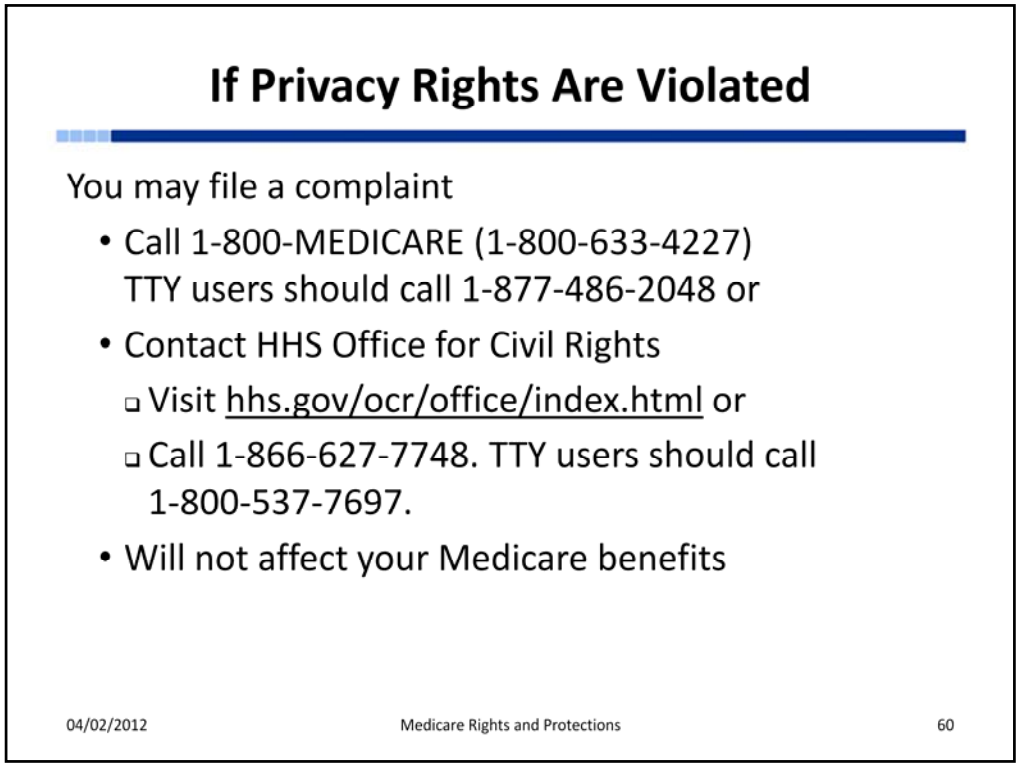


By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.



You have the following privacy rights. You may

- See and copy your medical information held by Medicare
- Correct any incorrect or incomplete medical information
- Find out who received your medical information for purposes other than paying your claims, running the Medicare program, or for law enforcement
- Ask Medicare to communicate with you in a different manner (e.g., by mail versus by telephone) or at a different place (for example, by sending materials to a P.O. box instead of your home address)
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request
- Ask for a separate paper copy of these privacy practices
  - If you want information about the privacy rules, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



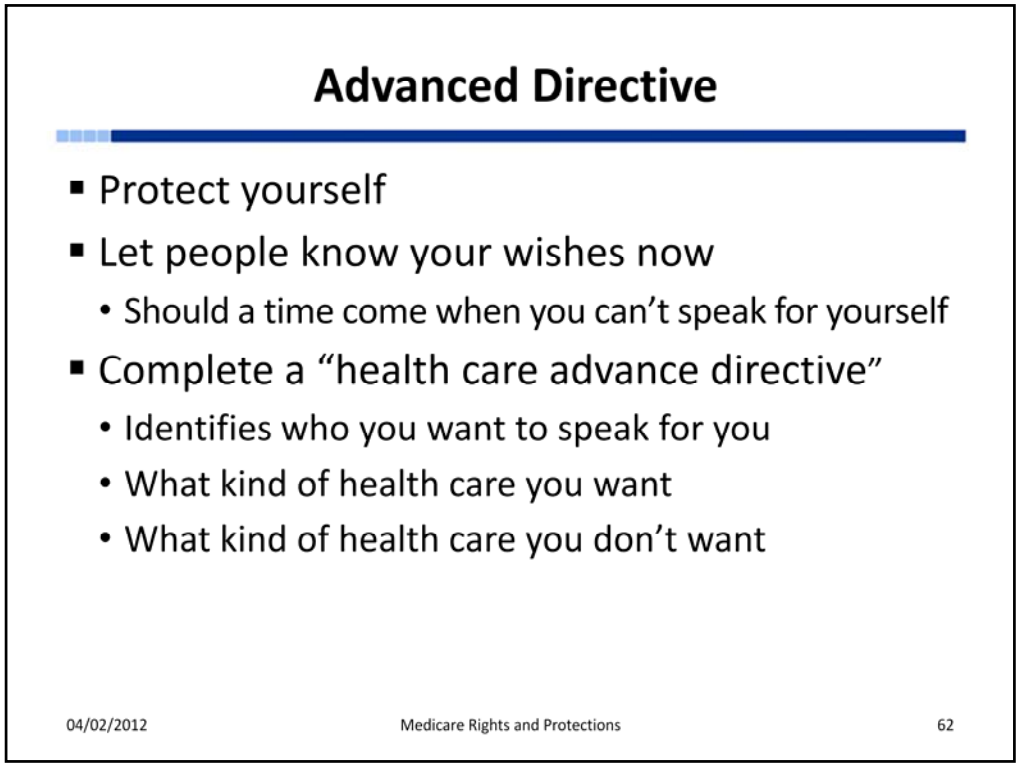
If you believe Original Medicare has violated your privacy rights, you may file a complaint.

You can file a complaint by

- Calling 1-800-MEDICARE (1-800-633-4227) and ask to speak with a customer service representative. TTY users should call 1-877-486-2048; or
- Contacting the HHS Office for Civil Rights at hhs.gov/ocr/hipaa or by calling 1-866-627-7748. TTY users should call 1-800-537-7697

Your complaint will not affect your benefits under Medicare.

Lesson 7 explains other relevant information and resources that are available to help you



As people live longer, there is a greater chance that they may not be able to make their own health care decisions at some point in time. Alzheimer's and other diseases affect your ability to make health care decisions.

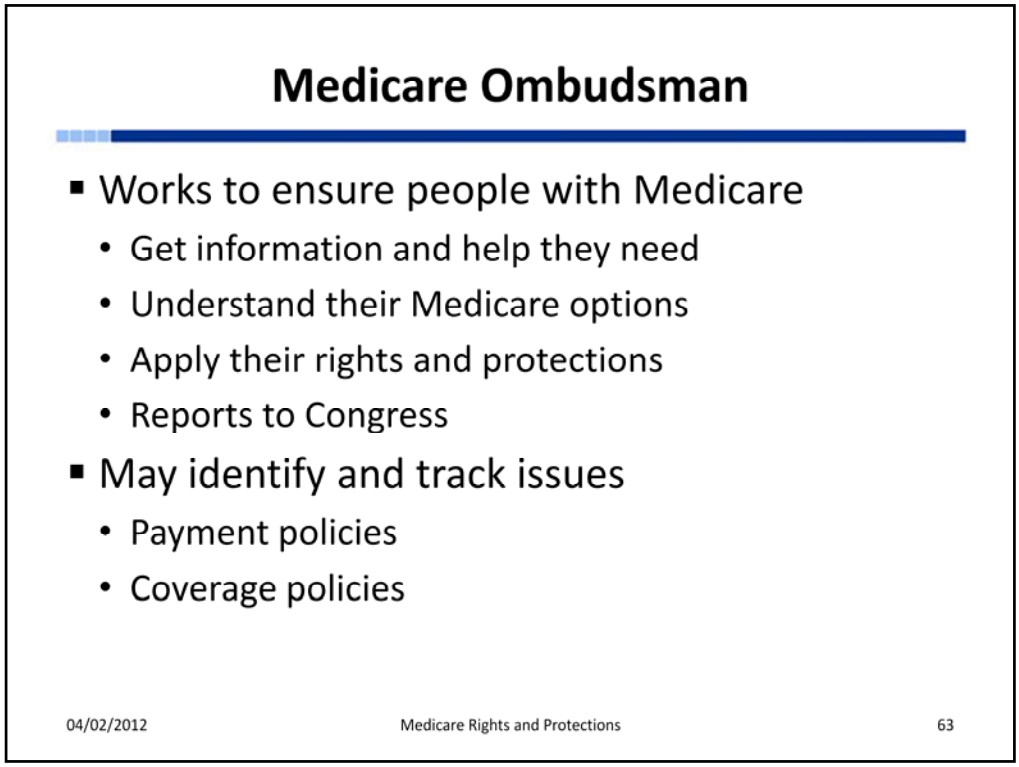
Making future health care decisions is another health care protection available to anyone, not just people with Medicare. Check for your state's requirements.

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include; a health care proxy (durable power of attorney), a living will, and after-death wishes.

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure your wishes are followed. It's better to think about these important decisions before you are ill or a crisis strikes.

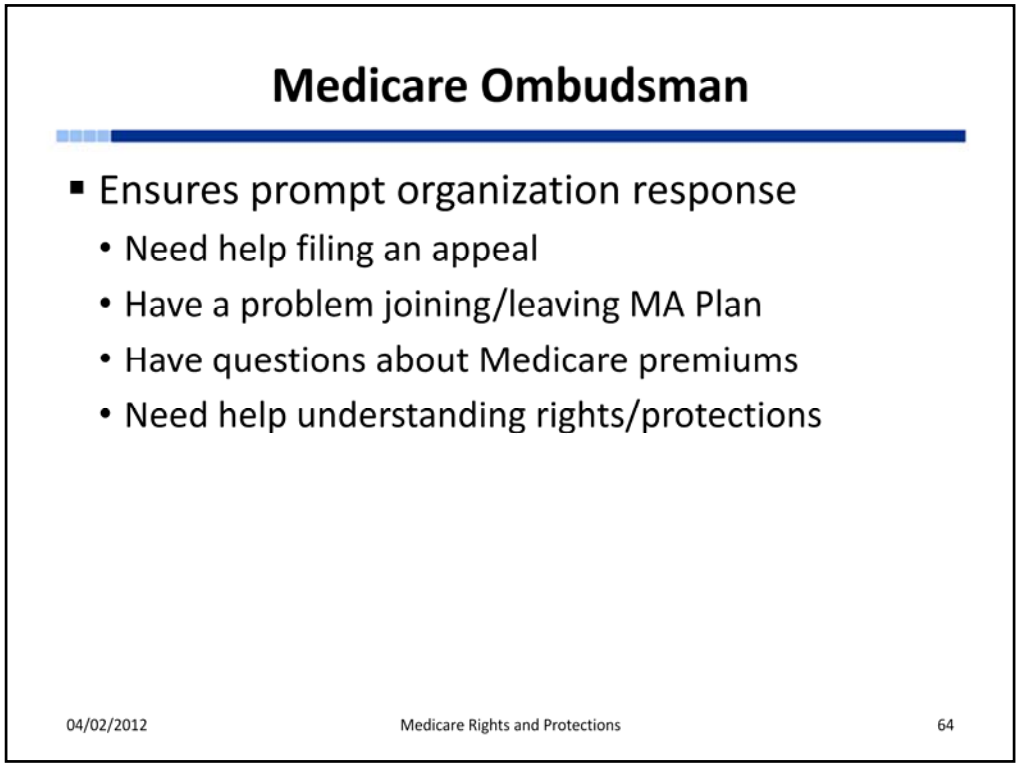
A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened, e.g.; dialysis for kidney failure, a breathing machine if you can't breathe on your own, CPR (cardiopulmonary resuscitation) if your heart and breathing stop, or tube feeding if you can no longer eat.



Another protection for people with Medicare is the Medicare Beneficiary Ombudsman's office. The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections.

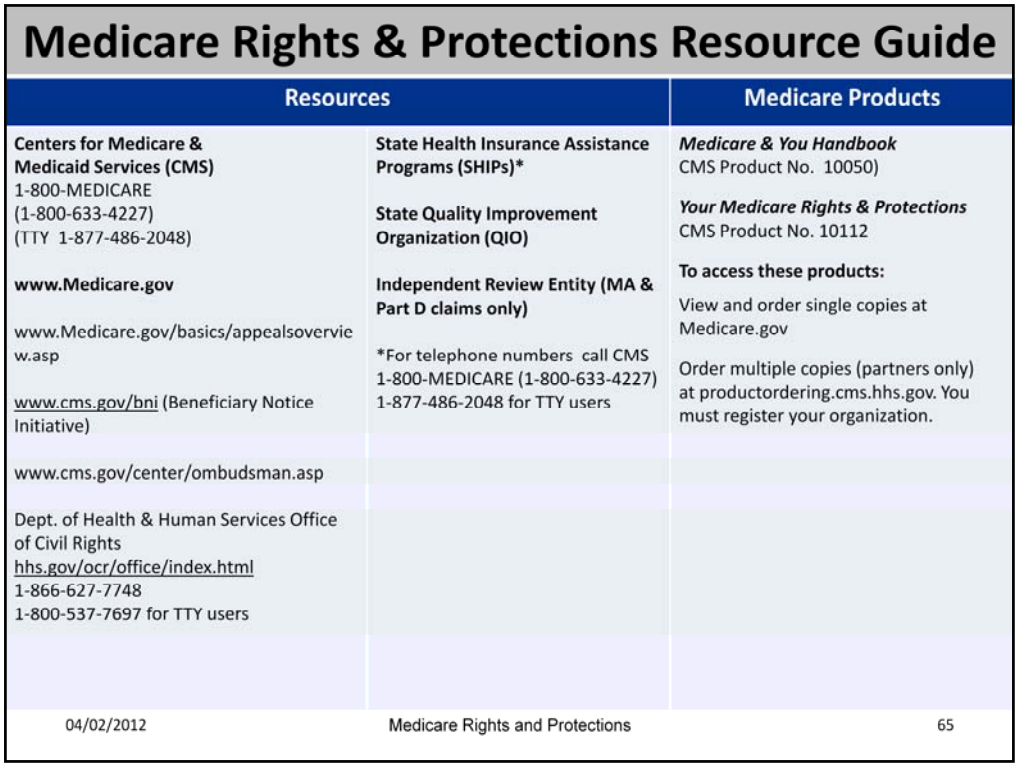
The Ombudsman may identify issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.



The Medicare Ombudsman works to make sure the organizations that should help you with your complaints, appeals, grievances, or questions about Medicare work the way they should and respond to you promptly.

For example, the Medicare Beneficiary Ombudsman can help in the following situations.

- You need help to file an appeal
- You have a problem joining or leaving a Medicare Advantage Plan (like an HMO or PPO) or other Medicare plan, or a Medicare Prescription Drug Plan
- You have questions about Medicare premiums
- You need help understanding your Medicare rights and protections



Medicare Rights & Protections Resource Guide

Resources		Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) **www.Medicare.gov** www.Medicare.gov/basics/appealsoverview.asp www.cms.gov/bni (Beneficiary Notice Initiative)	**State Health Insurance Assistance Programs (SHIPs)*** **State Quality Improvement Organization (QIO)** **Independent Review Entity (MA & Part D claims only)** *For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users	***Medicare & You Handbook*** CMS Product No. 10050) ***Your Medicare Rights & Protections*** CMS Product No. 10112 **To access these products:** View and order single copies at Medicare.gov Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.
www.cms.gov/center/ombudsman.asp		
Dept. of Health & Human Services Office of Civil Rights hhs.gov/ocr/office/index.html 1-866-627-7748 1-800-537-7697 for TTY users		

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Government resources for more information

Call the Centers for Medicare & Medicaid Services (CMS), 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

Beneficiary information is also available on Medicare.gov

Information on how to get answers to general questions about Medicare from the Medicare Ombudsman is available at cms.gov/center/ombudsman.asp

If you believe you have been the target of discrimination, call the Dept. of Health and Human Services, Office of Civil Rights (OCR) at 1-866-627-7748 or 1-800-537-7697 for TTY users. You may also visit the DHHS/OCR website at hhs.gov/ocr/office/Index.html

Industry resources for more information
State Health Insurance Assistance Programs (SHIPs)*
State Quality Improvement Organization (QIO)
Independent Review Entity (MA & Part D claims only)

For telephone numbers call CMS
1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users

Medicare Products
Medicare & You Handbook **(**CMS Product No. 10050)
Your Medicare Rights & Protections **(**CMS Product No. 10112)

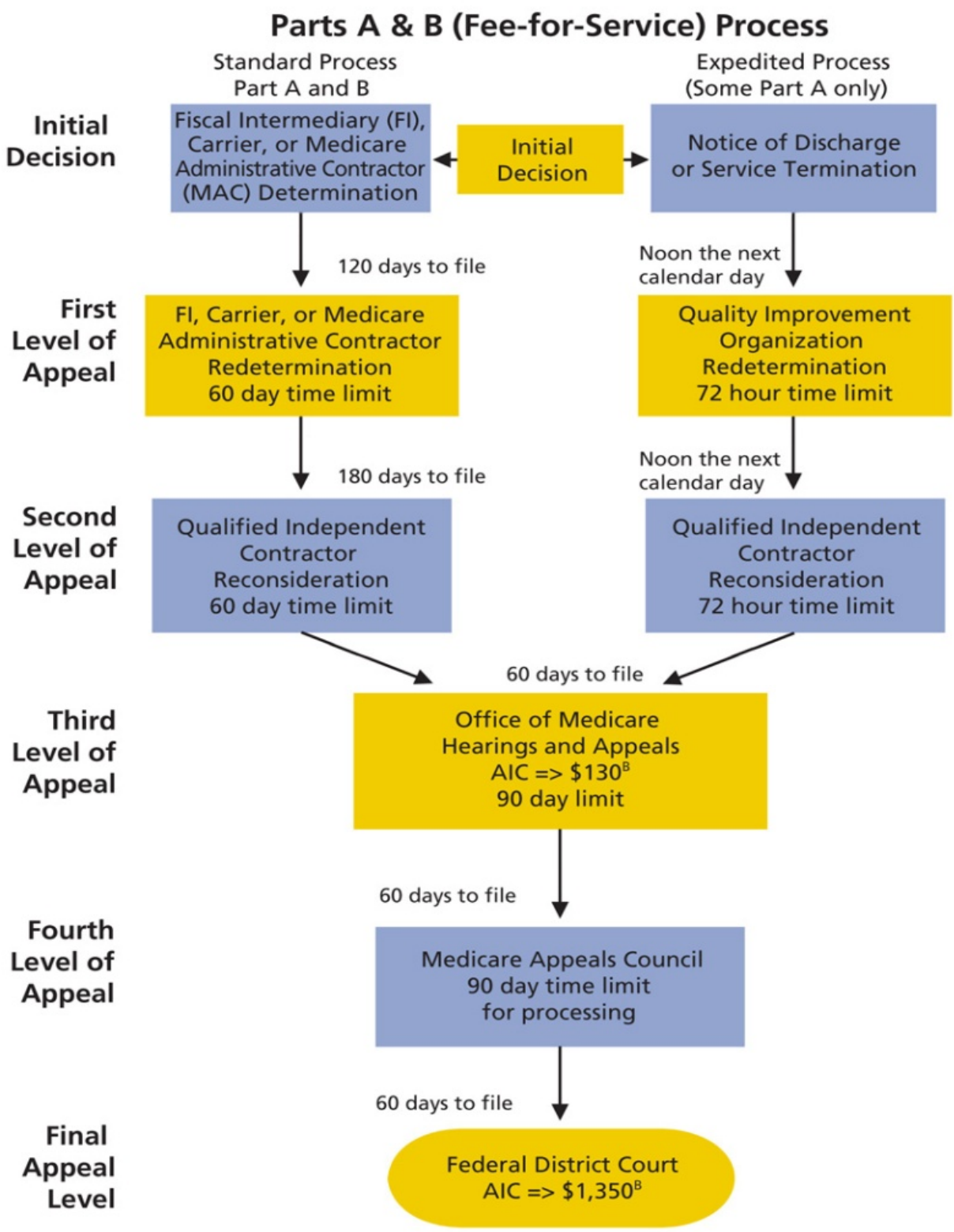
To access these products:
View and order single copies at: **Medicare.gov**
Order multiple copies (partners only) at: **productordering.cms.hhs.gov**. You must register your organization.

This training module is provided by the National Medicare Training Program.

For questions about training products, e-mail NMTP@cms.hhs.gov

To view all available NMTP materials or to subscribe to our listserv, visit cms.gov/NationalMedicareTrainingProgram

Appendix A


Parts A & B (Fee-for-Service) Process
Standard Process
Part A and B
Expedited Process
(Some Part A only)
Initial Decision
Fiscal Intermediary (FI), Carrier, or Medicare Administrative Contractor (MAC) Determination
Initial Decision
Notice of Discharge or Service Termination
120 days to file
Noon the next calendar day
First Level of Appeal
FI, Carrier, or Medicare Administrative Contractor Redetermination
60 day time limit
Quality Improvement Organization Redetermination
72 hour time limit
180 days to file
Noon the next calendar day
Second Level of Appeal
Qualified Independent Contractor Reconsideration
60 day time limit
Qualified Independent Contractor Reconsideration
72 hour time limit
60 days to file
Third Level of Appeal
Office of Medicare Hearings and Appeals
AIC => $130[B]
90 day limit
60 days to file
Fourth Level of Appeal
Medicare Appeals Council
90 day time limit
for processing
60 days to file
Final Appeal Level
Federal District Court
AIC => $1,350[B]

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

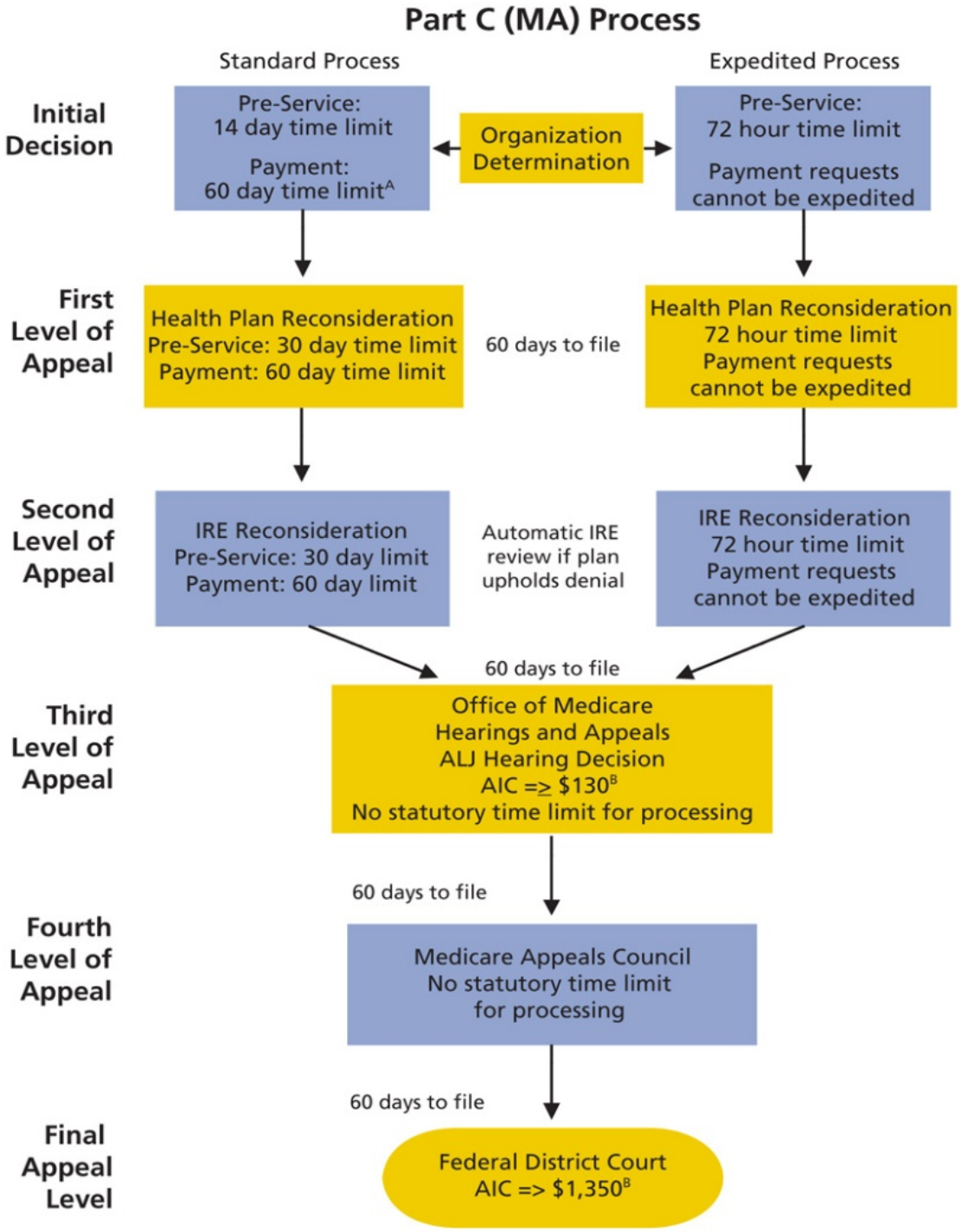
☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

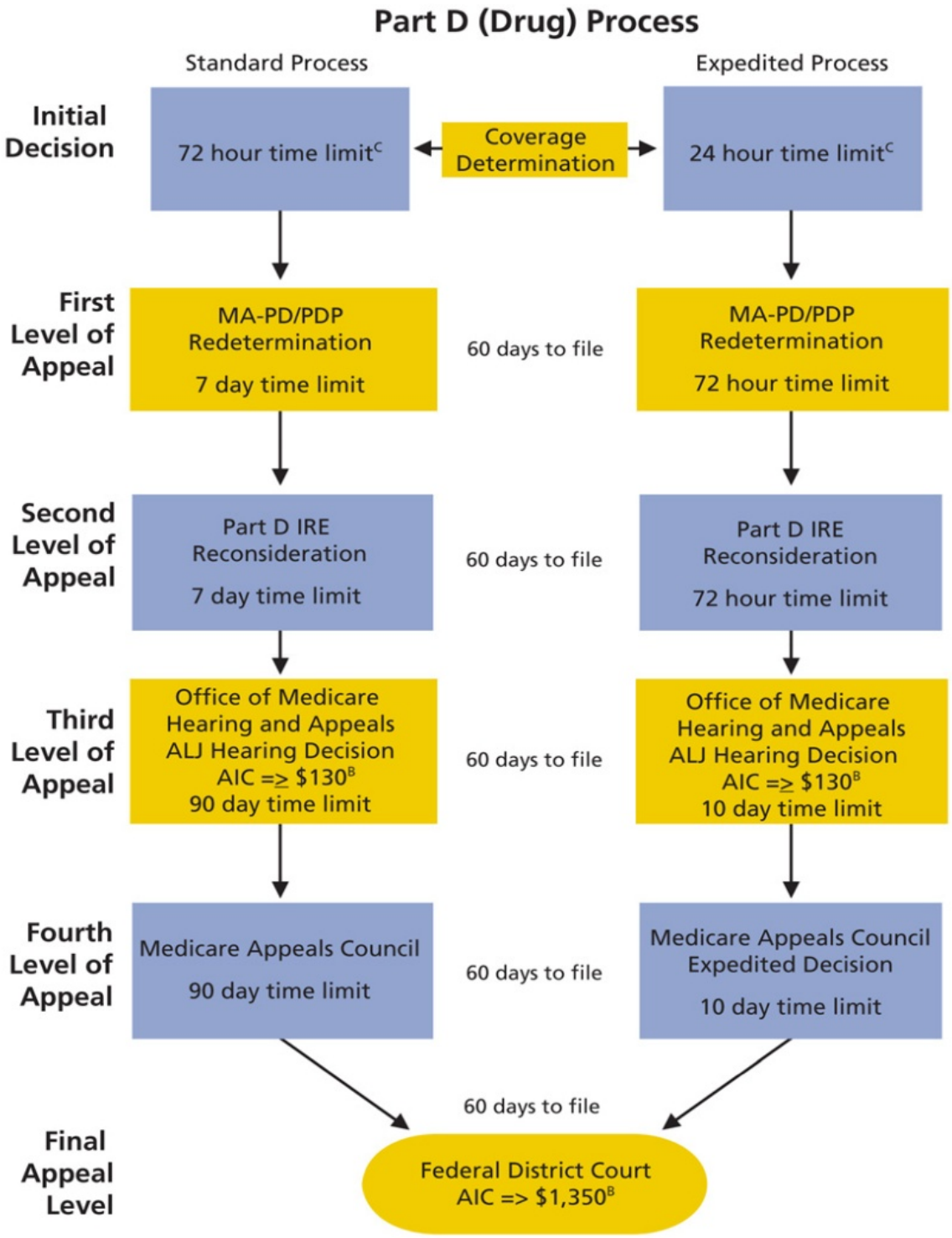
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Appendix C


Part C (MA) Process
Standard Process
Expedited Process
Initial Decision
Pre-Service: 14 day time limit
Payment: 60 day time limit[A]
Organization Determination
Pre-Service: 72 hour time limit
Payment requests cannot be expedited
First Level of Appeal
Health Plan Reconsideration
Pre-Service: 30 day time limit
Payment: 60 day time limit
60 days to file
Health Plan Reconsideration
72 hour time limit
Payment requests cannot be expedited
Second Level of Appeal
IRE Reconsideration
Pre-Service: 30 day limit
Payment: 60 day limit
Automatic IRE review if plan upholds denial
IRE Reconsideration
72 hour time limit
Payment requests cannot be expedited
60 days to file
Third Level of Appeal
Office of Medicare Hearings and Appeals
ALJ Hearing Decision
AIC =≥ $130[B]
No statutory time limit for processing
60 days to file
Fourth Level of Appeal
Medicare Appeals Council
No statutory time limit for processing
60 days to file
Final Appeal Level
Federal District Court
AIC => $1,350[B]

Appendix D


Part D (Drug) Process
Standard Process
Expedited Process
Initial Decision
72 hour time limit[C]
Coverage Determination
24 hour time limit[C]
First Level of Appeal
MA-PD/PDP Redetermination
7 day time limit
60 days to file
MA-PD/PDP Redetermination
72 hour time limit
Second Level of Appeal
Part D IRE Reconsideration
7 day time limit
60 days to file
Part D IRE Reconsideration
72 hour time limit
Third Level of Appeal
Office of Medicare Hearing and Appeals ALJ Hearing Decision
AIC =≥ $130[B]
90 day time limit
60 days to file
Office of Medicare Hearing and Appeals ALJ Hearing Decision
AIC =≥ $130[B]
10 day time limit
Fourth Level of Appeal
Medicare Appeals Council
90 day time limit
60 days to file
Medicare Appeals Council Expedited Decision
10 day time limit
60 days to file
Final Appeal Level
Federal District Court
AIC => $1,350[B]

E-mail: NMTP@cms.hhs.gov
Website:cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244